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

Consultation on draft guideline
Stakeholder comments table and responses

25/06/15 to 06/08/15

ID	Type	Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
	SH	Carers UK	Economic	General	General	The economic assessment should include working age people with care needs too. There is also evidence available on the consequences for carers where they miss out on practical and financial support because they are not identified and supported early enough in their caring journey.	Thank you for your suggestion. Whilst we appreciate the importance of identifying carers' supports needs early on in their caring journey, economic evidence which was not directly related to home to hospital transitions was beyond the remit of the scope for this guideline. The economic evidence relating to transtiions was reviewed and assessed for each review question across different populations including those of working age. Recommendations - including those that concerned people of working age - were informed by economic evidence where such was available. For example, economic evidence informed the recommendations in regards to early supported discharge planning, carers' support and end-of-life care. The rationale for focusing the additional economic analysis on comprehensive geriatric assessment and care is explained in Appendix C.
	SH	Health and Social Care Information Centre – Summary Care Records Programme	Full	general	general	The Summary Care Records (SCR) Programme has worked with GP IT System suppliers to create SCRs for over 96% of people in England. Core information in each SCR consists of details of the patient's medication, allergies and adverse reactions. Additional Information such as diagnoses, previous problems and/or procedures, anticipatory care information (including patient preferences), care plans, including End of Life Care pathways can be included with the patient's consent. SCRs can be viewed by authorised staff providing care to	Thank you for your comment. The information you have provided is extremely pertinent in light of recommendation 1.4.1 about recording patient information and multi-disciplinary assessments on electronic data systems, to which the hospital and community based multi-disciplinary teams have access. The information about Summary Care Records will be relevant to our work implementing this guideline but the Guideine Committee did not feel the evidence informing 1.4.1 provided grounds to make specific reference to SCRs in the recommendation itself.

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						the patient anywhere in England, any time of day or night. Implementation of SCR viewing in and organisation is straightforward and requires no major capital funding. SCRs provide a means of giving instant access to important information about an individual at the time when that information is most needed.	
	SH	Parkinson's UK	Full	general	general	We are extremely disappointed that the draft guideline makes no mention of, nor recommend having timely assessments for NHS Continuing Healthcare, which could enable smoother transitions between hospital and community social care for people with complex needs, such as those with advanced Parkinson's. The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care explicitly states: "*Arrangements for applying the Framework should form an integral part of local hospital discharge policies, and should be implemented in such a way that delays are minimised. Timely assessments will prevent whole system delays within the acute hospital sector. LAs, CCGs and other NHS bodies providing hospital services should ensure that there is clarity in local discharge protocols and pathways about how NHS continuing healthcare fits into these processes, and what their respective responsibilities are.*"	Thank you for your comment. Due to its remit, NICE is unable to make recommendations about specific types of funding; however, we recognise that health and social care funding in general can be a factor in preventing timely transition . In light of yours and other stakeholder comments, the Guideline Committee discussed the issue of timely funding assessments and were in agreement about the need to reflect it in the guideline. The Guideline Committee also felt that reference should be made to assessments for funding ongoing social care. They reached a consensus that 'assessments for health and social care eligibility' should be added to the list of factors that might prevent a safe, timely discharge from hospital (1.5.13). They also added 'how to arrange assessments for eligibility for health and social care' to the list of areas related to hospital discharge in which staff are trained (1.7.1).

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						The Framework suggests measures which will minimise potential delays which can occur in the transition process between inpatient hospital settings and community or care home settings as a result of NHS Continuing Healthcare assessments. We believe these must also be given due regard in this NICE Guideline. A report* produced by the All-Party Parliamentary Group on Parkinson's found that the process of applying for NHS Continuing Healthcare is both extremely complex and time consuming. It is clear, however, that this is exacerbated by delays within the process, resulting in individuals waiting for assessments. This can lead to delays in hospital discharge or people having to pay for the costs of care in the meantime. It is clear that agreeing funding arrangements for care when people are discharged is slowing down the system and causing delayed discharge. Age UK found that since June 2010 the NHS has lost almost two million bed days** owing to patients waiting for social care assessments, a care home place, a care home package or adaptations to be made to their own homes and so discharge is delayed. They estimated this cost the health	

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						service £526m during this period. Additionally King's Fund research released in January 2014 showed that 3,000 beds a day*** were occupied by people who were fit to leave but stuck in hospital while funding or assessment was resolved. We believe that the process of Continuing Healthcare assessments must always be considered and should begin as soon as possible following admission, to avoid unnecessary delays in hospital discharge, particularly if a person does not have a social care package arranged prior to their admission. *Failing To Care: The All Party Parliamentary Group report on NHS continuing care: http://www.parkinsons.org.uk/sites/default/files/failingtocare_appgfullreport.pdf ** Age UK, Nearly 2m NHS days lost from delayed discharge: http://www.ageuk.org.uk/latest-news/nearly-2m-nhs-days-lost-delayed-discharge/. ***King's Fund, A new settlement for health and social care (2014)	
	SH	HC-One	Full	general	general	We are concerned that there is no recommendation to involve Care Home services in the multidisciplinary process of discharging individuals back into their care or their	Thank you for your comment. The Guideline Committee agreed that in the case of transitions to or from a care home, the care home manager should be closely involved. They therefore agreed to add 'registered manager' (covering care

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						involvement in the process of risk management/care planning for Residents who may be at risk of going into hospital. Different process may be implemented across each local commissioning/local authority/NHS area which will impact on how Care Home organisations support this. Discharges planned to Care Homes- communication issues if Care Homes are not involved during the discharge process. Opportunity for reassessment visit from Care Home Manager not referred to in the draft guideline- particularly following a significant change in individuals care and support needs	homes and domiciliary care agencies) to the glossary definition of 'community based multi-disciplinary team', which the guideline recommends should be involved throughout admission and planning for a coordinated discharge. In addition, recommendation 1.3.3 now specifies that care home managers (as well as health and social care practitioners, including out of hours GPs), responsible for transferring people into hospital, should ensure the admitting team is given all available relevant information.
	SH	HC-One	Full	General	General	Question 2- If there was a standard electronic system that can be developed between hospital/GP local authority and care homes for records to be updated with changes in circumstances rather than relying on paper records for key information- medicines, next of kin details, changes to advance care planning.	Thank you for your comment. Recommendation 1.4.1 encourages hospital staff to record multidisciplinary assessments, medicines and individual preferences in an electronic data system during the hospital stay. The recommendation also states that this information should be made accessible to both the hospital- and community-based multidisciplinary teams, subject to information governance protocols.
	SH	HC-One	full	General	General	Question 4- The biggest impact on practice and challenging to implement would be Development of new teams and how it integrates in terms of current systems, the lack of inclusion of Care Homes could be detrimental to individuals particularly following discharge back to the Care home with changed care needs.	Thank you for your response to this consultation question. Ensuring effective communication of information was seen as a key implementation challenge by many respondents and the Guideline Committee agreed. We have highlighted that registered managers and their staff are key members of the multidisciplinary team. In the implementation section we have highlighted the Health and Social Care Information Centre's Transfer of Care initiative which is testing out improvements in communications with care homes.
	SH	HC-One	Full	Gene	Gene	We are concerned that despite it being	Thank you for your comment. As above, the Guideline

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				ral	ral	mentioned in the first section how to overcome the impact of poor preadmission assessment as Care Homes are not part of the recommendations. It should be built in at an early stage for individuals from Care Homes or going to Care Homes that the Home Manager is part of the discharge process to ensure that readmission becomes less likely and that the individual is supported fully when discharged.	Committee agreed that in the case of transitions to or from a care home, the care home manager should be closely involved. They therefore agreed to add 'registered manager' (covering care homes and domiciliary care agencies) to the definition of 'community based multi-disciplinary team', which the guideline recommends should be involved throughout admission and planning for a coordinated discharge. In addition, recommendation 1.3.3 now specifies that care home managers (as well as health and social care practitioners, including out of hours GPs), responsible for transferring people into hospital, should ensure the admitting team is given all available relevant information.
	SH	HC-One	Full	General	General	Question 5- Suggestions to overcome challenges- Inclusion of Care Home Manager or senior staff in the discharge planning process for individuals who have come from a care home or planned that they are going to a Care Home on discharge. Improvement in communication from hospital/to hospital/community/MDT using standardised discharge dpcuemtnation Care Homes should be included as part of the infrastructure for early discharge	Thank you for responding to this consultation question. 'Registered manager' (covering care homes and domiciliary care agencies) has been added to the definition of 'community based multi-disciplinary team' which appears in the 'terms used in this guideline' section. The guideline recommends that the community-based multi-disciplinary team should be involved throughout admission and planning for a coordinated discharge. We will also take account of your points as we consider activities and tool to support implementation of this guideline.
	SH	The British Association of Social Workers	Full	General	general	**NICE Guidance on Transition from hospital to the community** **General** The British Association of Social Workers (BASW) welcomes the draft NICE guidance the inclusion of principles from the Care Act and the Mental Capacity Act and the references to the contribution made by social workers. The recommendations for	Thank you for your response and your support of the Guideline's overarching principles of 'person-centred planning' and use of the MCA. .

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						good practice are however similar in many ways to that produced by the Department of Health following the 2003 Act ending with "Ready to go" (Department of Health 2010).[1] The recent crises in hospital accident and emergency services combined with the results of the Health Watch England survey (July 2015)[2] indicate that there is a need for a radical review of how people are treated in and when discharged from hospital. The NICE recommendations as they stand do not achieve this. 1 BASW supports the principles of person-centred planning and use of the MCA where appropriate 1.2.1 We agree with preadmission planning in principle but this is difficult to plan in practice where so many admissions are made on an emergency basis and sometimes unnecessarily. From experience it appears that health service procedures and processes favour emergency admission. Relatives and callers to GP services, out of hours GP services and the 111 service are often advised to ring 999, or visit A and E. It is reported that some GPs favour encouraging patients to go down the emergency route rather than look for a planned admission. Ambulance Crews are placed in a difficult position, with concerns about the responsibilities that may fall on them if they decide not to	**Thank you for your response. The Guideline Committee understands that some of the recommendations may seem challenging to implement from a pr**actice perspective but their intention was to make them aspirational and at the same time realistic. The Guideline Committee was aware that the level of preadmission planning they recommend may not always be possible, particularly in the case of emergency admissions. However they were in agreement that, especially for people identified as being at risk of admission, it is incredibly important that planning occurs in anticipation of a hospital admission. They also felt strongly that community as well as hospital based practitioners should contribute to this and be accountable for smooth transfers, whether or not the admission is classed as an emergency.

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						recommend assessment in A and E. They also will not know about and do not have easy access to knowledge about community support services. 1.3/1.4 Communication and Information sharing is often difficult during ongoing treatment particularly where responsibility is divided between different medical teams; this could be improved by the appointment of a **treatment rather than discharge** coordinator and deputy for each case from admission through to and during discharge. BASW feels that social work services in hospital could be developed further to support this service. Social workers have knowledge of communities, support systems and are skilled at working with individuals and families. In BASW's view it is essential that there are social work teams working within the health settings. Where such social work teams exist liaison with wards, out-patients and A and E is generally much more easily facilitated than when social work staff are not located in health facilities. Where such teams exist they are able to liaise with wards at a relatively early stage following admission and are able to alert ward staff and doctors about potential challenges to discharge. Guidance on information sharing with family	Thank you for you response. The Guideline Committee members were unanimous in their agreement about the need for a discharge coordinator, which was supported by the evidence review. The Committee also agreed that the value is in having a single individual coordinating people's discharge but did not want to stipulate how hospitals should allocate the role. The evidence did not support specifying which practitioner should take on the role so the Guideline Committee agreed it could be either a health or social care practitioner.

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						and carers could be more specific to guide hospital staff i.e. during stay family/carers should have regular meetings with key medical staff to discuss progress 1.5 12 We suggest that NICE looks again at a minimum standard for home assessment on the basis of the findings of the Health Watch England survey to ensure that all necessary plans have actually been made. We also suggest that discharges should not be made during unsocial hours unless specifically planned and carried out with the involvement of carers/family	Thank you for your response. The evidence underpinning recommendation 1.3.5 about providing information to people and their carers and giving them an opportunity to discuss their care did not provide sufficient detail to be able to specify that regular meetings should occur. 1.5.12 Thank you for your response. The NICE recommendations have been developed on the basis of the best available evidence of effectiveness, cost effectiveness, views and experiences and the expertise of the Guideline Committee as well as expert witness testimony. The review team were not able to include the Health Watch England survey in the review as it is lacking any description of its methodology and it would therefore not be possible to appraise its quality . As such, the Guideline Committee were unable to recommend its use for identifying factors that might prevent timely discharge, However, the 'discharge to assess' model for home assessments was identified as a major gap in evidence by the Guideline Committee and a research recommendation to ascertain the effectiveness of "Asessment at home to improve hospital discharge success rates" was made accordingly. The Guideline Committee believe that recommendations for future research will provide the basis for additional recommendations in this area. This guideline will be reviewed for update in the future and if published evidence is available on 'discharge to assess' when the review is undertaken the evidence can then be considered – but we cannot make recommendations for significant changes to practice without the appropriate evidence. The Guideline Committee agreed that on the basis of the evidence combined with their own expertise, they could not recommend that discharges be avoided at 'unsocial hours'. It may suit some people and their families for discharges to occur late in the evening when all necessary family or friends can be

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							available to support the process. On the other hand, this may seem 'unsocial' to others. The recommendations already make it clear that discharge planning should start early, be multi-disciplinary and coordinated and involve carers so that all support is in place at the point of discharge.
						1.7 The expertise and quality of care of providers is variable but is essential to the success of the treatment and transition process. The guidance should be more specific on the need for the involvement and training of provider managers and staff in both admission and discharge processes. Honesty is needed by all parties involved when sharing information to ensure that people can be effectively and appropriately supported both in hospital and in the community.	Thank you for this suggestion. We have now amended recommendation 1.7.1 to reflect that all relevant staff are trained in the hospital discharge process. By implication this includes, managers and staff. The evidence that was reviewed for this question only focussed on the effectiveness of training in the hospital discharge process, which explains the focus of this recommendation.
						Although not part of the brief of the consultation, one can't ignore the issue of adequacy or inadequacy of community support systems. There needs to be a recognition of the need to look at a whole system approach to hospital discharge, linked to prevention of hospital admission. Reference should be made to guidance on joint commissioning of services in the community that support prevention of admissions and discharge. This should not only be about services such as domiciliary support, but should include support to carers, voluntary sector schemes and community capacity.	Thank you for your response. As you note, admission avoidance is not within the scope of this guideline. However, 1.6.1 recommends that a range of local community health, social care and voluntary sector services are available to support people following discharge, with the aim of supporting recovery and independence and reducing readmissions. According to the remit of NICE social care guidelines, this is as far as the recommendations can go in terms of guiding local commissioning.

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						http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_116675.pdf [2] http://www.healthwatch.co.uk/news/getting-hospital-discharge-right-would-stop-suffering-and-save-millions-pounds-says-new-report	
	SH	London Fire Brigade	Full	General	General	The London Fire Brigade (LFB) embraces the principles set out in the draft guidance document on transition between inpatient hospital settings and community or care home settings for adults with social care needs. The LFB have a particular interest in this area due to the prevalence of such individuals in the occurrence of fatal fires and those where injuries were serious enough to require lengthy hospitalisation. The LFB have published evidence[1] that people with physical, mental and cognitive health issues are significantly	Thank you for your comment and your support for the guideline. The Guideline Committee was interested in the information provided and agrees with the value of conducting fire risk assessments. However none of the evidence reviewed covered this area and the reports you provide do not meet the inclusion criteria used in the evidence review process, which stipulates that included papers report primary research or systematic reviews. Please see appendix A of the guideline for details about the study methodologies that were considered for each review question. For these reasons, the Guideline Committee did not feel able to make specific recommendations in this area. They do however recommend that the discharge coordinator ensures the discharge plan takes account of the person's practicalities of daily living. They also recommend that training for staff involved in the hospital discharge process should include 'learning how to assess the person's home environment'.

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						at risk from fire. These risks could be identified through routine risk assessment – in this case, as part of the discharge planning for hospitalised individuals. The LFB also work with Skills for Care, the UK Home Care Association (UKHCA), the Care Quality Commission and the Prime Minister's Dementia Challenge Group to raise awareness of these fire risk factors and the means to reduce them. The underlying principle is that if an individual, through any physical, mental or cognitive health issue, is more likely to have a fire or to be unable to escape should a fire occur, that individual should receive a fire risk assessment. All UK fire and rescue services provide this assessment free of charge in such cases. Reports: Fire Safety of People in receipt of Domiciliary Care – FEP 1952 http://moderngov.london-fire.gov.uk/mgconvert2pdf.aspx?id=920 Hoarding and the impact on Fire Safety – FEP 1981 http://moderngov.london-	

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						fire.gov.uk/mgconvert2pdf.aspx?id=1146 Fire Safety for people with Mental Health issues – FEP 2303 http://moderngov.london-fire.gov.uk/mgconvert2pdf.aspx?id=3292	
	SH	Care and Repair England	Full	General	General	Most people in hospital want to go home as soon as possible. Enabling people to return safely home from hospital is not just about the efficient transfer and integration of medical and social care. Faster, good quality discharge from hospital also requires consideration of people's housing and living conditions. This includes fast track repairs and adaptations to ensure that the home is suitable for people to return home. A recent report from Age UK (http://www.ageuk.org.uk/latest-press/archive/age-uk-show-an-escalating-social-care-crisis-in-england/) identified that in the last year alone from (April 2014 to March 2015), shortages in 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. In summary this loss included •174,138 days waiting for a place in a residential home •215,662 days waiting for a nursing home place to become available	Thank you for your comment and your support for the inclusion of housing in this guideline.

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						•206,053 days for help from social care workers or district nurses to enable people to return to their own home •41,389 days for home adaptations ranging from grab rails to ramps and stair lifts. With the home in the majority of cases being the place/setting in which people receive their social care and health support decent, appropriate, warm, safe and secure housing has to be seen as a key ingredient in coordinating the transition between hospital and home for older people many of whom will have disabilities and long term conditions including dementia. Unsuitable home conditions can directly cause health problems, 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. 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 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. Evidence shows falls are a major	

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						contributor to hospital admission/readmission and that home hazards contribute to falls. 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 prevention. We welcome the references to housing in the guidance and have suggested where the guidance could go further	
	SH	Care and Repair England	Full	General	General	*The Care Act 2014 sets out new housing duties for local authorities to promote integrated health and care. How can local authorities and housing providers better help to assist the type of transition this guideline describes* Question 1: The Care Act expects local councils to ensure the integration of care and support including housing. There is recognition that the suitability of living accommodation is a core component to enable people to live independently and a recognition that getting housing right can help to prevent falls, hospital admissions and readmissions. Housing authorities can help with transition in the following ways • Through local planning and housing strategies ensuring that there is enough suitable housing available for older	Thankyou for your very full response to this consultation question. We have emphasised the important role of housing at key points in the document. In particular we have highlighted that, in line with the Care Act 2014, the guideline covers health-related provision (including housing) as well as health and other care and support. We will draw your helpful suggestions to inform consideration of activities or tools to support implementation

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						people and those with care and health needs. This includes ensuring that existing housing is well maintained and repaired and, where appropriate, adapted to meet needs. It also includes developing lifetime homes and age friendly housing as well as specialist housing options based on robust local needs assessments • Through active participation in local Health and Well Being Boards and CCG's assessing what housing is needed to support health and social care services and how housing services can support hospital discharge schemes/ transitions • Through offering and funding housing services including Home Improvement Agencies, handyperson services and other practical support services around the home to enable people to stay independent • Through the funding and provision of independent, impartial housing, care and finance advice and information services working closely with hospitals and other health and care services to ensure older people and their relatives and carers can assess advice and information on the options available at the right time. An example of successful working in this field can be found in our work on 'If Only I had known' which shows the benefits of this type of work to older people and to saving health resources longer term See	

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						http://careandrepair-england.org.uk/?page_id=177 Housing providers can help with transition in the following ways • Engage with local Health and Well Being Boards and CCGs to plan housing that supports older people and those with care and health needs to live independently at home • Build lifetime homes and age friendly housing to prevent people finding their homes a barrier to independent living • Support the development and funding of Home Improvement Agencies to help people to repair and adapt their homes • Offer and fund adaptations services in their homes and schemes to support hospital discharge and the prevention admission due to housing factors (e.g. falls) • Support and contribute to the development of independent, impartial housing, care and finance advice and information services to ensure that people have information and advice at the right time	
	SH	City of York Council Adult Social Services	Full	General	General	**Continuing Health Care funding** is not mentioned specifically in the guidance but is an area that can delay discharge from hospital, either because of delays in the assessment or because of funding delays, e.g. for specialist equipment or specialist care home placement –	Thank you for your comment. Due to their remit, NICE is unable to make recommendations about specific types of funding; however, we recognise that health and social care funding in general can be a factor in preventing timely transition. In light of yours and other stakeholder comments, the Guideline Committee discussed

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						due to the commissioning / procurement arrangements, or due to lack of capacity in the hone care /nursing agency sector.	this issue of Continuing Health Care funding and were in agreement about the need to include it in some way. The Guideline Committee also felt that reference should be made to assessments for funding ongoing social care. They reached a consensus that 'assessments for health and social care eligibility' should be added to the list of factors that might prevent a safe, timely discharge from hospital (1.5.13). They also added 'how to arrange assessments for eligibility for health and social care' to the list of areas related to hospital discharge in which staff are trained (1.7.1).
	SH	City of York Council Adult Social Services	Full	General	General	**'People with complex needs'** - this phrase is used 16 times through the long document but I could not find a definition.	Thank you for highlighting this. The guideline will now signpost to the Think Local Act Personal (TLAP) definition of 'Complex needs': "You may have complex needs if you require a high level of support with many aspects of your daily life and rely on a range of health and social care services. This may be because of illness, disability or loss of sight or hearing - or a combination of these. Complex needs may be present from birth, or may develop following illness or injury or as people get older"
	SH	The Royal College of General Practitioners	Full	General	General	This is an impressive review of a difficult area, of the literature and a brave attempt to agree a way forward. The resource spread and best use of limited resources is critical as is the ability/wish of patient/carer/family to pay part of the costs. Information understanding, using and sharing is key, as is the need to audit regularly the process of care and how well the service performed against agreed outcomes. While there is a need to define a minimal standard there is also the need to allow differences in approach and care. (PS) The Confidential Inquiry into the deaths in people with learning disabilities CIPOLD	Thank you very much for your support. Thank you for this information. Whilst we recognise this as a key issue the Confidential Inquiry into premature deaths of

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						reviewed the deaths of 247 people with learning disabilities over the 2-year period in 2010–2012. http://www.bristol.ac.uk/media-library/sites/cipold/migrated/documents/fullfinalreport.pdf This study involved the transition between inpatient hospital settings and community or care home settings for many adults with social care needs and learning disabilities. Recommendation 4 is a named healthcare coordinator to be allocated to all people with complex or multiple health needs, or two or more long-term conditions. Can you consider this and the other recommendations of CIPOLD which did include comparator cases. (MH)	people with learning disabilities (CIPOLD) - Final report was not retrieved in the searches as it was not indexed as being specifically about admission/ discharge in the controlled indexing terms or title and abstracts. Please note that recommendation 1.3.6 now references the Equalities Act 2010.
	SH	Yorkshire and Humber Commissioning Support	Full	General	General	I would suggest that the term "carers" and "social care practitioners" are clearly defined in the document particularly if carer is only being used to mean informal carer rather than a social care provider otherwise I feel this will cause confusion in the social care sector.	Thank you for highlighting this. We have now clarified where we are referring to carers, as opposed to care workers. 'Carers' refers to 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.
	SH	Yorkshire and Humber Commissioning Support	Full	General	General	It is difficult from the document to understand where the need for information of care homes and domiciliary care staff are considered.	Thank you for your comment. The evidence review did not locate research specifically about the information needs of care home and domiciliary care staff in relation to transitions between hospital and community and care home settings. (Please see appendix A for details about the types and topics of studies being searched across each review question.) This lack of evidence explains why the Guideline Committee did not develop specific recommendations on this subject. However, wherever health and social care practitioners are

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							cited, then home care and domiciliary care staff would be included. For example, recommendation 1.1.4 states that all health and social care practitioners (as well as the person and their carers) should be in regular contact with each other so that the transfer is coordinated and all arrangements are in place. Where relevant this would include care home and domiciliary care staff.
	SH	Yorkshire and Humber Commissioning Support	Full	General	General	In my experience social care providers do not consider that "patient experience in adult NHS services" relates to them (probably because they are not NHS providers, in general). They are unlikely to have read the document. It would be helpful to put essential information into this document.	Thank you for this suggestion. As you can imagine, there are a number of NICE guidelines relevant to this one. It would be impractical to reproduce text from other guidelines so instead we cross refer to relevant ones, where appropriate, specifying particular sections. In the online version of the guideline, the cross references to other guidelines are hyper linked for ease of access. Please note that there is currently a NICE guideline in development called 'Service User and carer experience'.
	SH	Yorkshire and Humber Commissioning Support	Full	General	General	Improvements in the discharge process are to be welcomed. Some of the recommendations are going to very challenging to achieve within the current financial constraints and staffing levels within both acute settings and community settings.	Thank you for your comment. The Guideline Committee fully appreciates the challenging resource constraints, not least because most of them are practitioners in health and social care. Nevertheless, the recommendations they have made are based on the best available evidence of effectiveness and cost effectiveness and on their own expertise. They consider the recommendations are aspirational but realistic.
	SH	Royal College of Speech and Language Therapists	Full	General	General	Mental capacity which is mentioned quite often in this document and it should be referenced that speech and language therapists can introduce and support strategies to enable an individual to access information appropriately and express their views or intentions. There is frequent reference about capacity. However, our members report that in some acute settings capacity is not always assessed and medical teams make decisions in their patient's interest. There should be an increased emphasis on capacity and supporting individuals' especially with difficult or challenging	Thank you for your suggestions. As you can see, recommendation 1.1.3 states that the principles of the Mental Capacity Act must be followed where there is any doubt about a person's capacity to consent. This recommendation is not aimed at a specific professional group, which means that all those involved in a person's transition have a responsibility to establish whether the person can consent or to arrange for a suitable colleague to conduct this assessment. The review of research did not identify any specific evidence about the role of speech and language therapists in this context, which is why they have not been specifically cited here. We agree about the importance of supporting people with communication difficulties, which is reflected in

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						communication	recommendation 1.1.2, which states that as an overarching principle, people at risk of less favourable treatment should be identified and supported, including people with communication difficulties. In the final guideline we have also added that where appropriate advocacy should be offered. Recommendation 1.3.2 also states that the admitting team should identify and address people's communication needs at the point of admission. The admitting team will involve relevant practitioners.
	SH	Royal College of Speech and Language Therapists	Full	General	General	It is important to refer to the availability of any AAC equipment commonly used by the individual and to ensure they have access to this equipment when transferring between services.	Thank you for your comment. The Guideline Committee agree with your point and we have therefore added 'medicines and equipment' to recommendation 1.2.3 which states the issues and practicalities health and social care practitioners should be discussing with people on admission to hospital.
	SH	Stroke Association	Full	General	General	In the Context chapter you draw attention to the increased risk of emergency hospital admissions among care home residents. Stroke is the second most common neurological condition among care home residents and around 8,000 people are discharged from hospital to a care home after a stroke every year. The Stroke Association and Royal College of Physiotherapists commissioned 250 telephone interviews with workers and managers in UK care homes and nursing homes between 13th and 30th January. The survey found that stroke survivors in care homes do not get access to the sort of therapies that could increase their independence, improve their quality of life and, crucially, reduce the risk of readmission. We found that 3 in 5 care homes are not following	Thank you for your comment. Compared with other conditions, stroke treatment receives particular attention in these guidelines because the evidence review identified relevant research findings. The Guideline Committee was therefore able to recommend that people admitted to hospital following a stroke should be treated in a stroke unit and offered early supported discharge. Readers are also directed to the NICE guideline on stroke rehabilitation. The Guideline Committee was also able to specifically recommend training for carers of stroke patients.

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						Stroke Rehabilitation Clinical Guideline 162 that the needs of a stroke survivor must be followed up by a specialist within 72 hours of admission: http://www.theguardian.com/society/2015/mar/31/stroke-survivors-being-written-off-care-homes At present neither the NHS nor care homes are clear as to whose responsibility it is to ensure these assessments happen. These recommendations should set out responsibility and a framework for ensuring these assessments happen.	The evidence review did not identify any specific research about conducting the assessments you describe so the Guideline Committee was unable to develop the specific recommendations you describe.
	SH	British Specialist Nutrition Association	Full	General	General	We request that a reference to NICE CG32 and the associated NICE QS24 on Nutrition Support in Adults is be made, and recommended, to ensure that those adults who are at risk nutritionally are identified early. This would ensure the appropriate intervention is given as stated in NICE CG32.	Thank you for your suggestion. The review of evidence underpinning this guideline did not identify specific evidence about nutrition assessments during transitions between hospital and home, which is why there are no specific recommendations on this issue. However, the guideline is based on the premise that the whole range of health and social care needs (which would include nutrition) should be assessed and supported as early after admission as possible. Recommendation 1.3.7 also states that as soon as the person is admitted to hospital, a multi disciplinary hospital based team should be formed of relevant practitioners. Examples given include a dietician. Although we have not linked to NICE CG32, it will be included in the NICE transitions pathway.
	SH	Derbyshire County Council	Full	General	General	Question 1: Agree with the recommendations in relation to housing: however – time is often of the essence when working to assist people leaving a hospital setting, and this can cause specific challenges if housing adaptations are required. Housing providers could make already adapted properties available for temporary use, whilst a person's main home was adapted and/or have a cycle of newly adapted properties	Thank you for your response to this consultation question and for highlighting an example of local practice in your area. We will draw upon this as we consider activities and tools to support implementation. We will be encouraging organisations with relevant practice examples to submit them for inclusion in the NICE database for shared learning and wider dissemination.

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						i.e. a person moves into one, they 'give up' their previous property and the cycle moves on (the risk with that approach is that mostly, the adaptations should be bespoke to the individual, rather than generically 'accessible'). Also, the question of who covers the 'rental' for the intermediate property needs to be sorted out in advance; and especially whether the arrangement is part of a non-chargeable 're-ablement' package, or not. In Derbyshire, we are working with extra-care providers re: 'step-down' opportunities; and one of our Borough Councils (that still has access to housing stock) is keen to find a way of providing interim arrangements.	
	SH	Derbyshire County Council	Full	General	General	Question 2: Clearly, there is ongoing work taking place nationally and at local levels about the better IG and ICT co-operation and sharing, for example it is one of the Better Care Fund's (BCF) national requirements. The speedy provision of telecare/ assistive technology can make all the difference between a speedy and slow discharge in terms of mitigating risk.	Thank you for your helpful response to this consultation question. We have made reference to some of the national initiatives you refer to within the implementation chapter
	SH	Derbyshire County Council	Full	General	General	Question 4: If this was easy – we'd be doing it now, but it's difficult to get right; and the requirement of all BCF programmes nationally to have as part of their key indicator set both NELS and DToCs wouldn't have been set up. I believe there are two main challenges 1. Time – hospitals are under immense pressure to empty beds and move people on; undertaking the processes outlined are good practice, but immensely difficult to implement, especially if the person isn't feeling well/ 100% and therefore not able to fully engage in the process, their home environment requires adapting and finally, their relatives are just plain relieved that Mum/	Thank you for your response The Guideline Committee agree with the challenges you highlight and we have reflected them within the key implementation challenges

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						Dad is now 'safe', can't fall/ set fires/ wander off – and are really supportive of a swift and permanent move into residential care; 2. Care planning in the community – already taking place through the BCF programme nationally i.e. the risk stratification and identification of those people at risk of admission; I wish it wasn't so – but the IG challenges appear to continue, as well as the difficulty of incompatible ICT systems i.e. between NHS (GP stand-alone ICT software systems) and social care.	
	SH	Derbyshire County Council	Full	General	General	Question 5: clearly the national BCF programme and associated tools/ support structures/ learning opportunities/ sharing of best practice, including the Better Care Exchange england.bettercareexchange@nhs.net etc. etc. is a significant resource; but as indicated by your proposed list of research topics – there is still more to be refined/ better understood.	Thank you for your response. We have now highlighted the Better Care Fund Programme and associated initiatives in both the context section and within the implementation chapter. We will draw upon these points as we consider options for activities and tools to support implementation of the guideline.
	SH	Carers UK	Full	General	General	Carers are a vital part of the transition between hospital and community/care home settings. It is important that there is the right guidance in place for practitioners on how to support, inform and empower carers in the admissions, decision making and discharge processes. There will be many families who suddenly find themselves becoming carers overnight as their loved one is discharged from hospital; for long-term carers they could still experience new and difficult challenges with the person they care for, as their needs for support will often increase following discharge. These families need both support and preparation to provide the best care for loved ones without putting their own wellbeing at risk. For some this might be more simple	Thank you for your comment and the information provided. The Guideline Committee agrees about the crucial importance of involving carers throughout transitions between hospital and home and in ensuring they have the support they need during and following discharge from hospital. The review of evidence, as well as the Committee's expertise provided the basis for recommendations about involving and supporting carers. For example, recommendation 1.1.3 is derived from a good amount of evidence that including people and families in decision-making and preparation for discharge affects the quality of transitions from hospital. A number of recommendations throughout the guideline refer to involving or informing family carers and the Guideline Committee wanted an overarching recommendation to ensure that this happens, albeit with the consent of the person being admitted to or discharged from hospita

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						measures such as clear information about treatment and medication or the signposting of relevant services; but for others, social care support, support from community nurses or specialist therapists as well as training for the carer so they are able to care for their loved one will need to be put in place. All carers should be involved in the discharge procedure and any hospital discharge policy must emphasise the importance of involving the carer and the patient in all stages of discharge planning, so long as the patient consents. If the patient does not want the carer to be involved, then the hospital should still be informing the carer of this choice and their right to a carer's assessment emphasised. The discharge process must not put the patient or their carers at risk of harm and must not create a situation whereby the independence of the carers or the sustainability of their caring role is jeopardised. NICE guidance should reflect and encourage hospitals to take carer-friendly approaches – to involve carers in hospital admissions, discharge and decision making processes as well as recognising carers' roles as expert partners in care and providing them with the information and support they need to continue this role as they wish. Carers' views should be taken into consideration when a patient is discharged, especially as they will often become the primary caregiver post-discharge – so it is crucial the patient is not discharged before the necessary support for the	There is a specific section in the guideline focussed on involving carers during discharge planning and another on providing them with support and training. The strength of the evidence meant the Guideline Committee could develop a specific strong recommendation about training for carers of stroke patients and then extrapolate this to all carers in a 'consider' recommendation. The Guideline Committee therefore believes they have promoted the importance of involving and supporting carers throughout transitions with as much detail as they can in this guideline, on the basis of the best available evidence.

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						carer has been put in place. Yet at Carers UK, we hear from carers that they are not involved at key times such as discharge and this continues to be an area where hospitals are not putting in place the care and support that they should be. The continued pressure on social care budgets locally is in many cases contributing to the difficulty of getting the right support at home after leaving hospital. However, long-term, this is more costly as it can lead to emergency re-admission. Research conducted by Carers UK in 2013, found that 8 in 10 carers said the person they care for had been discharged from hospital in the last three years. Of these, 26% said that the person had to back into hospital within 1-2 months because their health deteriorated[2]. However, this figure rose to 31% for respondents who were not consulted about the discharge of the person they look after. Whilst it should always be with the consent of the person they care for, rarely is it due to a lack of consent that carers not consulted with but because health practitioners do not think to. It is hardly surprising that involving and consulting carers can help to prevent readmission because if a carer is unprepared or unable to care for their loved one when they are discharged, without support, the family can be put under huge stress and find it difficult to cope, making readmission more likely. Further research conducted by Carers UK in 2015,	

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[2] Carers UK State of Caring Report (2013)

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						found that 12% of carers who care for someone admitted to hospital in an emergency in the last 12 months felt that this could have been avoided with more time before discharge from hospital for enough care or other arrangements to be put in place. Of those who thought that the admission was preventable, 24% thought it could have been avoided with more support for them. One of the main challenges carers face in asserting their rights is that they often do not identify themselves or describe themselves as a carer. The NHS Commitment to Carers highlights the priorities for the NHS in identifying and supporting carers and should be referenced in this document www.england.nhs.uk/ourwork/pe/commitment-to-carers/ This issue is exacerbated when NHS staff do not think about the family around a patient and in many cases NHS culture can tend to be more patient-focussed than family-focussed. In order to overcome this, guidance must be explicit in that health practitioners should be active in identifying carers and ensuring a carer's assessment is carried out and where necessary a support plan is provided to the carer. We have produced the following Factsheet on *Coming out of Hospital* which is an important resource that should be of use to carers in the discharge process. It may also be helpful to staff in explaining to families what they can expect: www.carersuk.org/images/publications/Factsheet_E1014__Coming_out_of_hospital_England.pdf	

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						www.carersuk.org/images/publications/Factsheet_W1014__Coming_out_of_hospital_Wales.pdf	
	SH	Department of Health	Full	General	General	***How can technology be better used to assist communication between hospital and community or care home settings as described in this guideline?*** On this section, it would be worth reading the National Information Board '*Personalised Health and Care 2020*' document and speaking directly to the Health and Social Care Information Centre as there is a range of activities on going, including improving secure e-mail between care homes and hospitals, standards for electronic discharge notices, improved use of technology in the home for monitoring people etc.	Thank you for your response to this consultation question. The Guideline Committee agreed that effective communication of information is a key challenge for implementation of this guideline. We have added your suggested references to the section on implementation
	SH	Department of Health	Full	General	General	***What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.)*** • Reference to NHS England Sit Rep Guidance on DTOC counting. • Reference to Care Act regulations on discharge. • Reference to best practice on certain conditions – dementia, learning disabilities. • Homeless – reference to UCLH, Guys and St Thomas Homelessness pilot scheme.	Thank you for your response. We will take account of it as we consider priorities for activities or tools to support implementation of this guideline. In addition, we have clarified that the guideline has been developed in the context of and should be used in conjunction with the Care Act 2014. It would have been impractical to refer to relevant Care Act regulations throughout the recommendations, which is why we have made it clear that all recommendations should be considered in this context. In the development of the recommendations, the Committee was careful not to contradict any Care Act regulations and to avoid duplication. For example, the Committee considered recommendations about conducting carers assessments during discharge planning but ultimately agreed this was adequately covered by the Care Act regulations.

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	SH	Department of Health	Full	3	6	This is not a comprehensive list – it would be helpful to add in a) awaiting residential care, b) awaiting nursing care, c) awaiting further assessment/s. It may be helpful to look at the NHS England SitRep Guidance on Delayed Transfer of Care reporting for a full list.	Thank you for your comment. The list in the draft guideline was only intended to provide examples of the reasons for delays. However in light of your comment and to provide a comprehensive picture, we have amended the context section to provide the full list of reasons for delayed transfers, according to the NHS England SitRep figures. We have also updated the figures to give the latest available at the time of revising the guideline.
	SH	Care and Repair England	Full	3	11	We welcome the recognition of the suitability of home to hospital discharge	Thank you for your support. Committee members agree this is an important issue.
	SH	Care and Repair England	Full	4	5-6	Add 'for health and social care **and housing** practitioners' and also add **housing providers**	Thank you for your suggestion. We have not made this change to the intended audience for this guideline because it would not reflect the scope. However, on the front page of the short guideline, we have emphasized that the guideline covers health provision, health related provision and the provision of care and support. In line with the Care Act 2014, health related provision includes housing. As you have noted, we also emphasize the importance of assessing the suitability of people's homes during discharge planning and we specify that housing specialists are one of a range of professionals who could form the hospital based multi disciplinary team.
	SH	Care and Repair England	Full	5	27	We welcome the recognition of housing as part of health related services for promoting greater integration	Thank you for your support. The Guideline Committee members agree that housing is an important element of health related provision.
	SH	Cabinet Office	Full	5	27	Local authorities are required by the Act to consider a range of health related services; this includes local civil society organisations. We are concerned that there is a sole focus on statutory services within this guideline. This runs the risk of sidelining community volunteer-led services, which can play a vital role in providing care and support to people in the community in order to avoid or shorten hospital stays. It would therefore be helpful to include within this guideline, perhaps as part of the context section,	Thank you for your comment. The Guideline Committee agreed that the guideline should be clearer about the important role of the voluntary sector and we have therefore made a number of changes to the final document. For example, we have amended the description of the hospital and community based multidisciplinary teams to reflect that these should include voluntary sector practitioners and we have added 'voluntary sector services' to the list of services that should be made available to support people following discharge from hospital.

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						explicit reference to the importance of including voluntary organisations in discharge planning. For example, in a similar vein, the national tripartite produced its Operational Resilience and Capacity Planning guidance for winter 2014/15 requiring local systems to develop their engagement strategies in partnership with local civil society organisations.	
	SH	Yorkshire and Humber Commissioning Support	Full	6	13	The CQC document was amended and final version released in MARCH 2015 (not February as stated)	Thank you for highlighting this. We have amended the text accordingly.
	SH	Yorkshire and Humber Commissioning Support	Full	6	24	Small point but should "overtime" actually read "over time" (two words)?	Thank you for highlighting this. You are correct and this text has been changed in the final version.
	SH	Department of Health	Full	6	28	Need to review latest DTOC data, as the social care delays have been rising over the past few months.	Thank you for highlighting this. We have now added the data that was most recent at the time of re-drafting. These were the data released in August 2015.
	SH	Care and Repair England	Full	7	6	We suggest that you add the Memorandum of Understanding produced by NHS England, Public Health England and a range of social care, health, housing and local government organisations in Dec 2014 which shows that the right home environment can: • Delay and reduce the need for primary care and social care interventions, including admission to residential or nursing homes • Prevent hospital admission • Enable timely discharge from hospital and prevent re-admissions	Thank you for your comment. We have added a reference and a hyperlink to this document in the context section as suggested.

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						- Enable rapid recovery from ill-health or planned admissions. Web link is http://www.housinglin.org.uk/_library/Resources/Housing/Support_materials/Other_reports_and_guidance/A_Memorandum_of_Understanding_MoU_to_support_joint_action_on_improving_health_through_the_home.pdf	
	SH	Department of Health	Full	8	7	Healthwatch England also covers older people and those with a mental health condition. It would be useful to reference the whole scope of the report and as it is now published and include a link.	Thank you for your comment. We have highlighted in the context section as suggested that this report also captures the experience of older people and people with mental health difficulties and have provided a hyperlink to the findings of the Inquiry published in July 2015.
	SH	Department of Health	Full	8	12	Evidence from last winter and the cabinet office pilots suggests that the voluntary sector can play a very positive role in helping smooth discharge and supporting people back into their home. Our view is that it would be helpful for the role of the sector to be amplified within this context section, especially given strong messaging from the government to work closely with the VCS. Examples include the work of Age UK, British Red Cross and RSV last winter in helping people get back home (cooking a first meal, arranging transport), Age UK in supporting self-funders make timely decisions on future care options, and support to carers. It may also be worthwhile mentioning the work of hospices at end of life.	Thank you for your comment. We have added an additional reference in the context section to highlight the important role of voluntary sector as partners in care. The examples you highlight are very helpful too, since they highlight aspects of the voluntary sector contribution that it would be good to use to illustrate support that may be of benefit to people at different stages of their journey into and out of hospital. As part of our implementation support we will be actively encouraging organisations to send their examples for inclusion in the NICE database for shared learning so that they can be disseminated more widely.
	SH	Department of Health	Full	8	12	We would also suggest that there is a clearer mention of the independent care sector within the context section, given the vast majority of social care is now provided by the independent sector. It would be good to acknowledge their	Thank you for your comment. We have added content at two points in the context section to highlight the diversity of the market for care and support and, specifically, the role of the independent sector. We welcome examples to illustrate practice in this area for inclusion in the NICE

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						role and the need for local commissioners and acute providers to seek to work collaboratively with the independent care sector. Good examples would be encouraging 7 day per week transfers into residential care, new models of home care which ramp up healthcare elements immediately after discharge until people are settled.	database for shared learning and wider dissemination.
	SH	Department of Health	Full	8	12	Should there be a specific mention within the context section to the Better Care Fund, as initiatives under this fund should be helping avoid admissions and reduce transfer delays?	Thank you for your comment. We have specifically referred to the Better Care Fund in both the implementation and context sections.
	SH	Department of Health	Full	8	12	Should there be more commentary given to different models of discharge package – e.g. trusted assessor model, discharge to assess models, reablement packages etc?	Thank you for your comment. We have made some reference in the paragraph on 'the changing landscape' to examples of emerging practice. Even though we did not identify good evidence about this emerging practice. Guideline Committee members were very keen for us to point to a few examples to acknowledge the pace of change in this area. We would welcome specific practice examples that could be included in the NICE database for shared learning and wider dissemination as part of our implementation support.
	SH	Cabinet Office	Full	8	30	The Five Year Forward View states that a key factor for greater citizen empowerment is for the NHS to "become a better partner with voluntary organisations and local communities" (p4). Civil society has a vital role to play in the Chief Executive's view of new models of care, and as such should be incorporated further in this guidance.	Thank you for your comment. We have added specific reference in the context section to highlight the important role of voluntary sector as partners in care with reference to the Chief Executive's vision set out in Five Year Forward View.
	SH	Health and Social Care Informatio	Full	9	general	Recommendations 1.2.3 and 1.2.4 could be undertaken in the context of a conversation between the patient and the GP or other healthcare worker in Primary Care obtaining the patient's consent for important information about	Thank you for your comment. We agree that these discussions may take place between the individual and their GP. Equally, they may take place with other health or social care practitioners and the evidence review did not provide the Guideline Committee with a basis to specify exactly who

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		n Centre – Summary Care Records Programme				relevant diagnoses, previous problems, anticipatory care needs (including patient preferences) to be included in the patient's Summary Care Record, which is sourced from the GP electronic record and available to authorised staff providing direct care to the patient away from the GP surgery, anywhere in England, any time of day or night.	should have these discussions. Finally, please note that recommendation 1.2.4 has now been deleted because the Guideline Committee felt it was adequately covered by 1.2.3.
	SH	Health and Social Care Information Centre – Summary Care Records Programme	Full	10	general	Recommendations 1.3.1, 1.3.2, 1.3.3, could all be achieved by ensuring that provider organisations were fully compliant with the NHS Standard Contract for 2015/16, which mandates access to the GP record through SCR or a local integrated system supplemented by the SCR Service: **Paragraph 23.6:** **Summary Care Records Service** **23.6** Subject to General Condition 21 (*Patient Confidentiality, Data Protection, Freedom of Information and Transparency*) the Provider must ensure that all Staff involved in the provision of urgent, emergency and unplanned care are able to view key Service User clinical information from GP records, whether via the Summary Care Records Service or a locally integrated electronic record system supplemented by the Summary Care Records Service.' *http://www.england.nhs.uk/nhs-standard-contract/15-16/*	Thank you for your comment. The Guideline Committee felt it was important to be explicit about the nature of the information that should be recorded and given to the admitting team and they agreed that the community based practitioners making the referral to hospital should be responsible for ensuring that information is provided. The information you have provided is extremely pertinent in light of the recommendations about information sharing and it will be relevant to our work implementing this guideline However the Guideine Committee did not consider the evidence informing the recommendations about information sharing provided grounds to make specific reference to SCRs.
	SH	Cabinet Office	Full	12	17	Where civil society organisations will be involved in someone's transition from hospital, they too should be included in communications between	Thank you for your comment. In light of yours and other stakeholder comments we have now emphasized that practitioners from the voluntary sector would be part of hospital

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						the other coordinating parties involved. Where possible, they should be granted access to online records pertaining to the person, in order to fully coordinate the transition and avoid the person needing to repeat their wishes to each individual service provider.	and community based multi-disciplinary teams supporting people throughout transitions between hospital and home. We have also added a glossary definition of 'voluntary' sector which specifically includes 'civil society organisations'. In addition, we have added 'voluntary sector services' to the list of services that should be in place to support people following discharge from hospital.
	SH	Yorkshire and Humber Commissioning Support	Full	13	1-3	This paragraph does not appear to cover transfer to a care home or working with domiciliary care providers. Where social care providers are going to be supporting the person, it is essential that they get clear information also.	Thank you for highlighting this. Where we refer to transitions between hospital and home, care homes are included in this. However, to ensure this is explicit we have now changed recommendation 1.1.5 to say that people should be given information about their diagnosis, treatment and medicines when they are 'transferring between hospital and home, including care home'. We have also added 'registered managers' (including care home and domiciliary care managers) to the community based multi-disciplinary teams. It is these teams who should work with the hospital based team to ensure coordinated transitions (1.3.8) and who should have access to multi-disciplinary assessments and information about prescribed and non-prescribed medicines, subject to information governance protocols (1.4.1)
	SH	Parkinson's UK	Full	13	1.2.3	We welcome health and social care practitioners explaining the type of care a person may receive, prior to admission. However, we are disappointed that this does not mandate a discussion around medicines the person is currently taking, or the possibility of self-administration of medicines. As noted in section 1.13 of NICE's *'managing medicines in care homes' guideline**, *'Care home staff (registered*	Thank you for your comment. The Guideline Committee agreed about the importance of discussing medicines at this stage so we have added '(including medicines and equipment') to the discussion about daily routines. The Guideline Committee felt it was implied that the question of self-medication would be included in that discussion. In light of your comment we have also directed readers to the NICE guideline on managing medicines in care homes (SC1) in the overarching principles, at the beginning of this guideline. The NICE pathway on transitions will also include the managing medicines in care homes guideline.

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						nurses and social care practitioners working in care homes) should assume that a resident can take and look after their medicines themselves (self-administer) unless a risk assessment has indicated otherwise.' For people with Parkinson's, timely access to their medication is essential. Delayed or missed doses can cause a significant exacerbation in a person's symptoms which it may not be possible to fully recover from. A person with Parkinson's who did not receive their medication on time while in hospital explains: *'A nurse witnessed me 'freezing' in the corridor. I had seized up and was completely unable to move. She was horrified. She thought I'd had a heart attack.'* We therefore recommend that this element of the *'Managing Medicines in Care Homes'* guideline be acknowledged in 1.2.3, to ensure that inpatients have the hospital's self-administration policies discussed with them prior to admission and arrangements are put in place among hospital staff to ensure timely access to medication, if such policies are not in place. *NICE Managing Medicines in Care Homes, available at:	

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						https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations#helping-residents-to-look-after-and-take-their-medicines-themselves-self-administration	
	SH	Yorkshire and Humber Commissioning Support	Full	13	11	Is "assign" the correct word? Who will do the assigning? Essentially will this coordination fall to the person's GP? The community multidisciplinary team is much more disparate than the hospital team – including geographically, which can be a challenge.	Thank you for highlighting this. In order to clarify this, we have made changes to the recommendation. It should now be clear that the intention is for the community multi-disciplinary team to name a team member as a point of contact with the hospital multi-disciplinary team. We have also stipulated that the name of this contact be given to the person and their carer.
	SH	Yorkshire and Humber Commissioning Support	Full	13	27	Who will "find out" about the person's wishes and where will it be recorded?	Thank you for your comment. The Guideline Committee decided to delete this recommendation because they felt it was already adequately covered by recommendation 1.2.3.
	SH	Yorkshire and Humber Commissioning Support	Full	14	6	"Lists of medication in standard documentation" This could be a challenge in terms of keeping lists updated if/when medication changes so standardisation may be difficult. For example, care homes in this area send in a copy of the current up-to-date administration records (MAR charts) and protocols which seems to work well and gives information about whether the person is actually taking the medication or not without adding another level of documentation. The important thing would be that hospital ensures it has a complete, accurate and up to date list of current medication (prescribed and purchased) when the person is admitted and that they use relevant resources to check this, such as GP records (if they have access). Similarly on discharge the hospital should provide such a list to the GP, patient and both formal and informal carers, as appropriate.	Thank you for your comment. The list of bullets has now been deleted from this recommendation. The Guideline Committee felt that a list of this nature, which cannot be exhaustive, risks omitting certain types of information and thereby implying that they should not be collated or shared. Also, not all the listed information would be appropriate to every adult with social care needs being admitted to hospital.

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	SH	Yorkshire and Humber Commissioning Support	Full	14	7	Does "carer" here include the care home/social care staff where they are the main source of support? If not I feel it should.	Thank you for your comment. Please see above where we describe the reasons for deleting this list altogether.
	SH	Yorkshire and Humber Commissioning Support	Full	14	8	Should this also include any person with legal authority to act on behalf of the patient (in the event of lack of capacity?) For example, a person with lasting power of attorney for health and welfare.	Thank you for your comment. Please see above where we describe the reasons for deleting this list altogether.
	SH	Yorkshire and Humber Commissioning Support	Full	14	16	Who will determine what is "relevant"? – It is appropriate that non-health care staff (social care staff) or informal carers/family should be asked to make that judgement? In an urgent case an out of hours GP may not have access to all this information. Would it appropriate to include "available information"?	Thank you for your comment. The Guideline Committee changed 1.3.3 and and 1.3.4 to say 'available relevant', recognising that not all information will be available, especially, as you say, to out of hours practitioners such as GPs. This list given in 1.3.3 gives guidance on the information that would be relevant in the event of a hospital admission.
	SH	Care and Repair England	Full	14	24	We welcome the inclusion of housing status	Thank you for your support.
	SH	Yorkshire and Humber Commissioning Support	Full	14	26	Would it be helpful to specify "support and care needs" in the "other profiles", if this is known?	Thank you for your suggestion. In light of this we have added care plans to the list of information that should be given to the admitting team. With this addition as well as all the other information in this recommendation, the Guideline Committee feel support and care needs are adequately covered.
	SH	Care and Repair England	Full	14	28	It would be helpful to define 'places of care'	Thank you for your suggestion. The Guideline Committee considered your comment and decided not to make a change to this bullet point. 'Places of care' could be any place in which care and support is provided and the Guideline Committee wanted to keep this phrase deliberately broad. This information may be particularly relevant to people with end of life care needs.
	SH	Yorkshire and	Full	15	7-14	The admitting team can only provide this information **as far as is possible**. Acute care	Thank you for your comment. The Guideline Committee has deliberately chosen not to differentiate between planned and

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		Humber Commissioning Support				needs can change rapidly and the information may not be known at the point someone is admitted. Probably is more practical for planned admissions.	emergency admissions as best practice should apply across both types of admission. The Committee agreed that practitioners should aim to follow all recommendations in the event of both emergency and planned admissions.
	SH	Yorkshire and Humber Commissioning Support	Full	15	1	Would "**available** relevant information" be appropriate?	Thank you for your suggestion. The Guideline Committee agreed with your point and we have now changed the recommendation to read 'available relevant information'.
	SH	Parkinson's UK	Full	15	1.3.6	We believe that self-administration of medication policies should also be included as part of 'reasonable adjustments', as this will enable people to receive their medication in a timely manner and will prevent their condition from worsening unnecessarily. Ascertaining the ability of a person with Parkinson's to self-administer their medication in hospitals and care homes is essential to ensure those who are able can maintain their complex medication regime. The NICE Clinical Guideline on Parkinson's* includes a specific reference to the importance of getting medication on time and self-administration policies. The guideline, which is currently under review by NICE, specifically states medication should be *'given at the appropriate times, which in some cases may mean allowing self-medication.'*	Thank you for your suggestion. The Guideline Committee did not feel that self-administration of medication is a reasonable adjustment in the sense of the Equalities Act 2010. However, your comment led them to review the examples listed and the three now given in recommendation 1.3.6 are clearly reasonable adjustments rather than ways in which everyone should be treated.

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						A 2013 YouGov survey** completed by 4,777 people who have either been diagnosed with the condition or are family members or carers of people with Parkinson's, found that of those having been in hospital or a care home, 30 per cent reported not receiving their medication on time. Furthermore, an online survey of people affected by Parkinson's undertaken in 2012*** found that only 16% (out of 98 respondents) got their medication on time, every time during their most recent hospital admission. Respondents were also asked about the opportunity to self-administer their own medication. Only 13% (out of 97 respondents) were able to self-administer their medication every time. 53% reported not being given the opportunity at all. In some cases, this had been deemed inappropriate due to the person's medical status at that time, however quite often the reason given was that this was against hospital policy. In order to gain an insight in to the practice of self-administration across the UK, Parkinson's UK sent Freedom of Information requests in October 2013 to 181 Trusts and health boards for information on the existence of an organisational self-administration policy and whether they were	

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						being actively utilised. Out of the 88% of trusts and boards that responded, 17% of trusts/boards reported they did not have a self-administration policy in place. However, it was harder to ascertain the level and quality of implementation through the requests. Having NICE guidelines in place which recommend the use of self-administration policies will play an important part in improving provision and ensuring a smooth transition between inpatient hospital settings and community or care home settings for adults with social care needs. *NICE, *Parkinson's disease: Diagnosis and management in primary and secondary care* ** Parkinson's UK and YouGov, *Survey of people with Parkinson's and their friends, family and carers*, 2013 *** Parkinson's UK, *Getting Parkinson's medication on time*, 2012.	
	SH	Yorkshire and Humber Commissioning	Full	15	4	It would be helpful to include care home staff in this discussion/information if the person has been admitted from a care home, if possible.	Thank you for this suggestion. We have not added care home staff to this particular recommendation because it is specifically about ensuring people and their families are provided with information on admission. It is based on evidence and Guideline Committee consensus that people normally have to

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		Support					ask for this information rather than being included in discussions. However, accepting your point about the involvement of care home staff during the admission process, recommendation 1.3.3 has now been changed to show that care home managers as well as other health and social care practitioners and out of hours GPs are responsible for providing the admitting team with all available relevant information about the person being admitted. We have also deleted 'transferring people from the community' to be explicit that admissions from care homes are included just as admissions from home or other community settings.
	SH	Carers UK	Full	15	22	With regards to facilities for carers, we welcome additional facilities for carers and would encourage hospitals to introduce carer-friendly schemes more widely – e.g., free or discounted parking for carers.	Thank you for your comment. The Guideline Committee agrees with the importance of supporting carers throughout transitions between hospital and home. However, please note that Committee members reached a consensus to remove the example 'adequate facilities for carers who stay with the person in hospital'. This is because, having reviewed that recommendation, they wished to use examples that are clearly reasonable adjustments, in terms of the Equalities Act 2010. The Guideline Committee was concerned that the wording of the original recommendation would be understood to mean that carers should be provided with on-site accommodation, which was not the intention. Recommendation 1.3.6 in the final guideline now refers to adjustments in line with the Equalities Act, rather than broader, potentially unachieveable provisions.
	SH	Yorkshire and Humber Commissioning Support	Full	15	27	Prior to admission there may not be an established community based multidisciplinary team, with the exception of the GP and informal carers. Or is the guidance intended to mean that the hospital team should help establish who will be needed in the community?	Thank you for your comment. The Guideline Committee accepts that there may not be an established community based multi-disciplinary team for every person but where there is one, they should be in contact with the hospital based multi disciplinary team if the person is admitted to hospital. To clarify, the recommendation now reads 'where a community based multi-disciplinary team is involved in a person's care…'
	SH	Cabinet Office	Full	15	29	The community multidisciplinary team should include representatives of any civil society organisations providing services to people with long-term conditions in the community. This will	Thank you for your suggestion. The Guideline Committee agrees and we have therefore added 'voluntary sector practitioners' to the members of both the hospital and community based multi-disciplinary teams. The glossary

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						ensure they are kept updated of the person's circumstances and are able to ensure provision of the necessary services upon discharge. It would be helpful to outline who might be included in the community-based team, as has been done with the hospital-based team. Cabinet Office has been running the Reducing Pressures in Hospitals Fund, through which seven pilots are testing how social action interventions can best assist in reducing hospital admissions, readmissions and delayed discharges. A full impact report from this work is due in December 2015, but a key piece of learning so far has been that volunteer-led services need to be thought of as an equal partner in order to be able to facilitate discharges to the community. Even where senior hospital management are in support of incorporating volunteer support in their discharge processes, voluntary organisations can still struggle to embed in the discharge system. Our grantees have been successful in supporting high numbers of people where they have been able to walk the wards in order to pick up referrals and have been placed on discharge boards in order to remind clinical staff of the services available. This has been particularly demonstrated by Westbank in Devon, which runs a Neighbourhood Friends programme to resettle people at home. Therefore this guideline could facilitate this integration of volunteer-led services in the discharge planning process, by making reference to good working practices where	definition of 'voluntary sector' includes 'third sector' and 'civil society' organisations. Thank you for highlighting this practice example. As part of our implementation support we will be encouraging organisations to submit relevant practice examples to NICE for shared learning database and further dissemination.

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						voluntary organisations are a key part of the discharge planning team.	
	SH	Yorkshire and Humber Commissioning Support	Full	16	25-29	Is the secure technology widely available for this? If there is not the technology available or funding for it this will become impossible to meet. This may be more of a target to work towards rather than an absolute must do. During hospital stays plans and treatments are likely to change so there is a risk that community teams may act on information which is not current if the record is not adequately updated or they access it at an early point in the process. Most social care providers do not have secure electronic transfer available which could be used for sensitive patient specific data. (Some do not have computers readily available to staff.)	Thank you for your comment. You are right that this recommendation is not worded as a 'must do' because it is not a legal duty. The recommendation is derived from evidence, which describes the negative consequences of practitioners failing to share information, and suggested means of addressing this through electronic systems. Expert testimony about information sharing for end of life care patients concurred although the Guideline Committee agreed that information sharing via electronic systems should support transitions of all adults with social care needs, not just people at the end of life. It was important to the Guideline Committee to make this recommendation and knowing that such systems are established in some places, they believe it to be realistic as well as aspirational.
	SH	Department of Health	Full	16	9	1.3.7 – In this list, should the voluntary sector not be referenced as they can be part of the MDT? Also, does it have to be "hospital based" social worker – could it not be any social worker? Should there be a reference to housing specialists (especially if dealing with homelessness).	Thank you for your suggestions. We have now changed the description of the hospital based multi disciplinary team to include social worker (rather than hospital based social worker) and to include voluntary sector practitioners, which we have also added to the glossary definition of community based multi disciplinary teams.
	SH	Care and Repair England	Full	16	16	Add 'assessing their health, social care **and housing** needs'	Thank you for your suggestion. This guideline does cover health related provision (including housing) and this explanation has been added to the front page of the short guideline. However, the Guideline Committee did not review any evidence about assessing housing related needs at the point of admission so they have not made this addition to recommendation 1.3.9. The section on discharge planning does however recommend that the discharge coordinator should discuss the need for specialist equipment and support as soon as possible with practitioners that specifically include housing practitioners. It also recommends that they discharge coordinator should identify practitioners (including housing

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							practitioners) who will support the person following discharge from hospital.
	SH	Yorkshire and Humber Commissioning Support	Full	16	19	Practitioners should refer to existing plans where they exist – would it be appropriate to also include updating the plans if required.	Thank you for your suggestion. The Guideline Committee did not feel that it would be appropriate to recommend the care plan be updated at the point of admission. This is something that should be undertaken as part of the discharge planning process.
	SH	Department of Health	Full	16	25	1.4.1 – Not all systems will have electronic systems but should be encouraged. May want to reference that for those systems with real time patient flow systems specific processes may need to be agreed to support the system. It may be helpful to speak to organisations that have electronic systems in place e.g. *Well Connected* in Worcestershire	Thank you for your comment. The Guideline Committee understands that electronic systems will not be available everywhere. However it was important to the Guideline Committee to make this recommendation and knowing that such systems are established in some places, they believe it to be realistic as well as aspirational. The recommendation is derived from evidence, which describes the negative consequences of practitioners failing to share information, and suggested means of addressing this through electronic systems. Expert testimony about information sharing for end of life care patients concurred although the Guideline Committee agreed that information sharing via electronic systems should support transitions of all adults with social care needs, not just people at the end of life. The evidence underpinning this recommendation did provide sufficient detail for the Committee to be able to include the specific point about real time patient flow systems. Thank you for highlighting the example of where electronic systems are in place. As part of our implementation planning we will be encouraging organisations to submit examples of relevant practice for the NICE shared learning database and for wider dissemination.
	SH	Cabinet Office	Full	16	27	As above, where civil society organisations are involved in providing services in the community to help the person manage their health, they should be part of the community-based multidisciplinary team and have access to online	Thank you for your suggestion. The Guideline Committee agree and have now added voluntary sector practitioners to both the hospital and community based multi-disciplinary teams. A glossary definition of voluntary sector has been added which includes third sector and civil society

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						records recording the person's progress and individual preferences.	organisations.
	SH	Parkinson's UK	Full	17	1.4.2	At each shift handover and ward round, staff should be made aware that a person with Parkinson's has a self-administration regime in place and that they should be supported to manage their own medication, where possible.	Thank you for your comment. The research that the Guideline Committee reviewed did not provide specific evidence that would enable them to refer to particular conditions in this recommendation. Given that the recommendation states that multi-disciplinary assessments, prescribed (and now non prescribed) medicines as well as individual preferences should be recorded and made accessible, this is likely to include details about self-medication regimes and it applies to adults with all needs and conditions.
	SH	Yorkshire and Humber Commissioning Support	Full	17	4	Would it be appropriate to clarify which "people"?	Thank you for your suggestion. The Guideline Committee agree and we have changed recommendation 1.4.3 to make it clear the intention is for people themselves to be updated about plans for their transfer from hospital.
	SH	Carers UK	Full	17	4	What does the guidance mean by 'people' – is this families/carers or hospital staff? Needs to be specified	Thank you for your suggestion. The Guideline Committee agree and we have changed recommendation 1.4.3 to make it clear the intention is for people themselves to be updated about plans for their transfer from hospital.
	SH	Department of Health	Full	17	10	This section on providing care seems thin. Should there be a broader reference, beyond just stroke, to note that the care team should consider the most appropriate discharge package for their condition. There is also concern over other specific groups where early discharge planning would be beneficial – dementia, homeless, mental health issues, learning disabilities – and further research into these groups might be helpful.	Thank you for your comment. The Guideline Committee agree that the sub section on 'providing care' seemed rather thin so this sub heading has now been removed as has 'communication and information sharing'. There is now one single section entitled 'During hospital stay'. With regards to developing recommendations about other specific groups please note that the focus of the Guideline was on key priciples for transition; it would have been unmanageable to look across all the specific groups that this would be relevant to. The evidence reviewed was limited to stroke patients – we did not search specifically for this sub-group, but this is what was located by the the search. Recommendation 1.4.5 is based on good economic evidence that shows that stroke unit care provided with early supported discharge and multi-disciplinary community care is likely to be

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							cost-effective when compared with usual care. The Guideline Committee did discuss whether the findings could be extrapolated to other groups with high needs but ultimately agreed that the stroke unit setting and stroke patient population were specific to the research and findings. Finally, please note that in recognition of a lack of evidence in this area, a recommendation has been made for research on transitions between general hospital and home for people with mental health difficulties.
	SH	Department of Health	Full	17	22	1.5.1/2 – Again a mention of the VCS and also potentially the independent care sector (e.g. care home staff should be involved in assessing the individual to ensure that they are a good fit for the home).	Thank you for your comment. Recommendations 1.5.1 and 1.5.2 have not been amended in line with your suggestion because while there will be a range of health and social care practitioners involved in the discharge planning process, the point is to have a single discharge coordinator coordinating their input. The recommendations are based on evidence of the benefits of having a single individual coordinating discharge from hospital. The Guideline Committee were unanimous in their support for this but they decided against stipulating exactly how hospitals should allocate the role.
	SH	Cabinet Office	Full	17	23	The discharge coordinator should also be a point of contact for other service providers, including civil society organisations. They should ensure that they are fully aware of all community services available to assist the person, whether they have previously engaged or not. This will allow the relevant volunteer-led services to be incorporated into the discharge plan.	Thank you for your comment. The Guideline Committee decided against a change to this recommendation because they believe that all relevant practitioners are covered by 'health and social care practitioners', from whichever sector. However, they agreed it would be appropriate to make explicit reference to ensuring that voluntary sector as well as other local services are available to support people following hospital discharge (1.6.1). In addition, recommendation 1.5.17 states that the discharge coordinator should identify practitioners from the voluntary sector as well as other services who will provide support when the person is discharged.
	SH	Care and Repair England	Full	17	27	Add health and social care **and housing**	Thank you for your comment. Please note that recommendation 1.5.3 has now changed to show that 'health and social care organisations' should agree clear discharge planning protocols. The Guideline Committee did not review evidence that would enable them to specifically state that

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							housing organisations should have this responsibility.
	SH	Cabinet Office	Full	17	28	Discharge planning protocols should include processes for making referrals to civil society organisations for the provision of services in the community.	Thank you for your comment. We have not specified the content of discharge planning protocols but we have included recommendations in the guideline (section 1.6) that emphasise the role of voluntary sector services in supporting people during their transition from hospital.
	SH	Yorkshire and Humber Commissioning Support	Full	18	12-18	This refers to carers – does this include social care staff? Most social care staff are not healthcare workers and clear information and training is required particularly around specialist techniques (for example enteral tubes, invasive techniques of medication administration). There is also an issue of delegation of the task from healthcare to social care and who is responsible for assessing competence as required by CQC regulations. This can be an issue in the community and ongoing care needs should be address prior to discharge. It is important to provide the patient with this information and training also, where appropriate.	Thank you for your comment. This recommendation was specifically about unpaid carers, including family carers and does not cover social care staff. Recommendation 1.7.1 covers the training of social care and other staff in matters relating to hospital discharge. The scope of this guideline does not extend to the training of social care staff in specialist techniques but other guidelines are likely to pick up on this issue, including the recently published NICE Home care guideline.
	SH	Yorkshire and Humber Commissioning Support	Full	18	8-11	Would this be an opportunity to consider the contents of the discharge summary – or could there be a link to relevant available guidance?	Thank you for your comment. We did not find any research evidence to enable us to make recommendations about the precise content of the discharge summary. However we have included a glossary definition for 'discharge summary' in the short and long version of the guideline and this covers what might be included i.e. the diagnosis, outcomes of investigations, changes to treatment and the medicines started or stopped, or dosage changes and the reasons why.
	SH	Yorkshire and Humber Commissioning	Full	18	19 - 22	Is there a reason that this is just the end of life patients? Many other patients go home with equipment also. What happens after 24 hours or is it assumed that care has transferred to another provider at this point?	Thank you for your comment. The evidence reviewed by the Guideline Committee was specifically about end of life care. However the Guideline Committee reached consensus to extrapolate to all people with complex needs. The new recommendation (1.5.9) has been agreed as: "The discharge

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		Support					coordinator should consider providing people with complex needs and their families with details of who to contact about medicine and equipment problems that occur in the 24 hours after discharge."
	SH	Parkinson's UK	Full	18	1.5.6	Although we accept the principle of the recommendation, for people with Parkinson's and other complex long-term conditions, the GP is rarely the centre of a person's health care in the community. This is more frequently the Parkinson's nurse specialist or another health professional. For this reason, we recommend that the wording is amended to say – *'The hospital-based doctor responsible for the person's care should ensure the discharge summary is sent to the person's GP* ***or their preferred provider of community healthcare*** *within 24 hours of their discharge. They should also ensure a copy is given to the person the day they are discharged.'*	Thank you for your comment. The evidence reviewed by the Guideline Committee was specifically about communication with the GP. There are likely to be other people involved in the person's care who may also be sent a copy of the discharge summary. However, this will vary from person to person and the Guideline Committee wanted to retain the emphasis on importance of sharing with the GP.
	SH	Parkinson's UK	Full	18	1.5.7	Parkinson's UK supports the aim of ensuring 'carers' are provided with information and support on a person's condition. However, the wording of the recommendation means it is unclear whether the term 'carers' refers to friends and family who provide care in an unpaid capacity, or paid care workers. We believe that both of these groups should be briefed on a person's condition ahead of discharge, although the information needs of each	Thank you for your comment. The term carers in this context refers to family and other unpaid carers and is defined in the TLAP Jargon Buster referenced at the end of the recommendations in the short guideline. The evidence reviewed by the Guideline Committee which led to this recommendation was specifically about family and other unpaid carers.

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						group will vary. For example, unpaid carers will need more practical advice and signposting to appropriate services than paid carers.	
	SH	Department of Health	Full	18	10	1.5.4 – 1.5.20 - Surprised that there is no reference to the Care Act here – and the specific regulations around discharge planning? Referencing the legal duty to issue assessment and discharge notices for those leaving acute care and in need of ongoing social care? Specific regulations around when continuing healthcare assessments should happen etc. There is also no reference to where it is best for assessment to take place – in the home/ or in hospital? Also no reference to Continuing Health Care and how these work vis-à-vis a social care assessment. ECIST – Emergency Care Intensive Support Team – should have further evidence.	Thank you for your comment. The Guideline Committee felt that the Care Act and its underpinning principle of well-being are so important in influencing implementation of this guideline that, rather than signpost to many relevant sections throughout the guideline, we should highlight this at key points such as in the context, introduction and implementation chapter. We expect that the guideline should be used in conjunction with relevant statutory guidance. There is no specific reference to where assessments should take place as the best available evidence did not show this. However, in the context section we do acknowledge that there are emerging models of practice that are testing this out. The Guideline Committee agreed that reference should be made in the training and development section at 1.7.1 to ensure that all relevant staff are trained in the hospital discharge process – including assessments for health and social care eligibility
	SH	Carers UK	Full	18	12	We welcome the guidance making clear that one member of the hospital-based multidisciplinary team should be responsible for providing carers with information and support. We would recommend stating that as well as including information on carer's rights to assessments and support packages it also includes information about benefits; especially as later in the guidance it notes that 2013 research into carers' experiences of Early Supported Discharge found provision and delivery of information to be key, with one carer noting that it would be good to talk about benefits because, until this point, many have never had any experience of	Thank you for your comment. We have chosen not to specify the types of information and support that could be offered as the list would be extensive. This recommendation (drawing from the evidence) specifically concerns the ways in which information and support can be offered.

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						claiming benefits. This could be as simple as signposting, although it was also mentioned in the same research that it was preferable to have someone sit down and talk over the situation with the carer face-to-face.	
	SH	Cabinet Office	Full	18	13	Information to be provided to carers should include access to local peer support groups, which can help reduce the incidence of carer breakdown.	Thank you for your comment. We have chosen not to specify the types of information and support that could be offered as the list would be extensive. This recommendation (drawing from the evidence) specifically concerns the ways in which information and support can be offered.
	SH	Department of Health	Full	18	19	1.5.8. – Obviously vital at end of life, but it should be good practice for anyone leaving hospital to have details of who to contact should there be a problem?	Thank you for your comment. The evidence reviewed by the Guideline Committee was specifically about end of life care. However the Guideline Committee reached consensus to extrapolate to all people with complex needs. The new recommendation (1.5.9) has been developed as: "The discharge coordinator should consider providing people with complex needs and their families with details of who to contact about medicine and equipment problems that occur in the 24 hours after discharge."
	SH	Parkinson's UK	Full	19	1.5.12	We welcome early examination of factors that could prevent or delay transfers of care. However, we insist NHS Continuing Healthcare assessments are acknowledged as a source of delays. Please see comment 1.	Thank you for your comment. The Guideline Committee agree and have added the need for assessments for eligibility for health and social care to the list of bullet points in 1.5.13.
	SH	Yorkshire and Humber Commissioning Support	Full	19	4	"try to" could be removed from this sentence.	Thank you for your comment. The Guideline Committee agree and we have replaced 'try to' with 'ensure'.
	SH	Department of Health	Full	19	11	1.5.12 - The list does not look to be comprehensive. What about: • Adaptations to own home? • Carer issues?	Thank you for your comment. The bullets provide examples of factors that could be addressed rather than a comprehensive list of everything that should be addressed. However the Guideline Committee agreed to make an addition concerning

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						- Funding issues? - Transport?	assessments for eligibility for health and social care funding.
	SH	Care and Repair England	Full	19	After line 14	Add **suitability of current housing**	Thank you for your comment. The bullets provide examples of factors that could be addressed rather than a comprehensive list of everything that should be addressed.
	SH	Department of Health	Full	19	15	1.5.13 - Plus the voluntary care sector? And the carer?	Thank you for your comment. Voluntary sector practitioners have now been added to the definitions of hospital based multidisciplinary teams (see 1.3.7) and community based multidisciplinary teams (see glossary). Involving carers in discussions is one of the overarching principle of this guideline for applies throughout (see 1.1.3).
	SH	Yorkshire and Humber Commissioning Support	Full	19	22	Would it be appropriate to also link this to the information in "managing medicines in care homes" recommendation 1.7.3 also – It is very similar but care homes will be more used to this guidance.	Thank you for your comment. We have now included reference to guidelines 'managing medicines in care home' and 'medicines optimisation' in one of the overarching principles concerning communication and information sharing (see 1.1.4)
	SH	Department of Health	Full	19	28	1.5.16 - We know that the voluntary sector can play a significant role here.	Thank you for your comment. We have added a reference to the voluntary sector to 1.5.17 and we have amended the final bullet of 1.5.15 to read 'details of other useful community and voluntary services'.
	SH	Cabinet Office	Full	19	26, 28	Arrangements for social care support should include services provided by civil society organisations locally, and these should be fully outlined in the details of other useful community services.	Thank you for your comment. We have amended the final bullet of 1.5.15 to read 'details of other useful community and voluntary services'.
	SH	Royal College of Speech and Language Therapists	Full	20	1.5.18	Any specialist equipment, aids and support should be in place at the point of discharge, this should include communication aids and equipment.	Thank you for your comment. The recommendation already includes the line "Ensure any essential specialist equipment and support are in place at the point of discharge". The Guideline Committee did not think it necessary to list the types of equipment this might include.
	SH	Care and Repair	Full	20	6	We welcome the mention of housing	Thank you for your comment.

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		England					
	SH	Cabinet Office	Full	20	6	It would be helpful for civil society service providers in the community to be referred to here, to ensure that these services are engaged with and represented in the discharge plan.	Thank you for your comment. We have added a reference to the voluntary sector to 1.5.17.
	SH	Care and Repair England	Full	20	13	Amend to the discharge coordinator should discuss **the need for housing adaptations, repairs** and specialist equipment	Thank you for your comment. The Guideline Committee considered your response, but decided that the reference to 'housing adaptations' and 'essential specialist equipment and support' sufficiently address this issue.
	SH	Care and Repair England	Full	20	16	Add any specialist equipment, **repairs and adaptations** should be in place at the point of discharge	Thank you for your comment. The Guideline Committee considered your response, but decided that the reference to 'housing adaptations' and 'essential specialist equipment and support' sufficiently addresses this issue.
	SH	Yorkshire and Humber Commissioning Support	Full	20	17	Is this intended to be in hospital or in community?	Thank you for your comment. The discussion is intended to happen in hospital, before discharge.
	SH	Yorkshire and Humber Commissioning Support	Full	20	20	Is this for both formal and informal carers? If not, could it be?	Thank you for your comment. The evidence reviewed by the Guideline Committee related to people using services. The GC agreed to extrapolate this to unpaid carers (see definition of carer in TLAP Jargon Buster) but did not feel the evidence enabled them to extrapolate further to paid care workers or practitioners.
	SH	Yorkshire and Humber Commissioning Support	Full	20	22	Could this not also be considered for other medical issues such as COPD?	Thank you for your comment. The evidence was specifically about supportive self- management for people with mental health problems and the Guideline Committee did not feel it appropriate to extend to other medical issues.
	SH	Department of Health	Full	21	10	1.5.25 - Not sure that we fully understand why under a heading 'early supported discharge' has only social care included. Could this not equally apply to those with a health condition? Again	Thank you for your comment. This guideline is focused on adults with social care needs. Early supported discharge is a particular intervention which was identified in the evidence review work. This recommendation was derived directly from

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						does there need to be a reference to the Care Act. It is also possible that someone could be discharged early to a residential care placement – i.e. it does not just have to be home care.	economic evidence statement 3, which synthesizes good quality evidence in favour of the cost effectiveness of early supported discharge with a home care and rehabilitation package for older people. The Guideline Committee decided that the importance of the Care Act should be emphasised and key context and that this guideline should be read in conjunction with it, rather than to specify relevant sections for each recommendation
	SH	Cabinet Office	Full	21	15	A home care and rehabilitation package should refer to any relevant community services provided by civil society organisations, including those which can enable early discharge: for instance, assistance with ensuring the person's home is safe and ready for their return for rehabilitation to commence immediately.	Thank you for your comment. We acknowledge that the voluntary sector can have an important contribution to make and have highlighted this potential role in the context section.
	SH	Department of Health	Full	21	17	1.5.27 - Should there not be a specific reference to the GP?	Thank you for your comment. We believe the term community based health practitioners covers GPs as well as the range of other practitioners. We have separated the reference to a local authority housing options team so this is now a recommendation in its own right.
	SH	Cabinet Office	Full	21	19	Community-based health and social care practitioners here should also include reference to civil society organisations: volunteer-led services and peer support can help reduce the risk of a hospital readmission and so should be considered as part of the longer-term discharge plan before the person is discharged.	Thank you for your comment. Unfortunately we didn't find any evidence about the specific role of civic society organisations, volunteer-led services and peer support in reducing hospital readmissions.
	SH	Parkinson's UK	Full	22	1.5.36	We recommend that this recommendation is strengthened to ensure that families are offered guidance and training to fully support people with a range of complex, long-term conditions, rather than stroke alone. Parkinson's is an extremely complex condition, with a wide range of both motor and non-motor symptoms. It would therefore	Thank you for your comment. This recommendation was based on evidence concerning stroke patients. The Guideline Committee agreed to extrapolate the evidence to create a recommendation for the multidisciplinary team to 'consider' this for people with conditions other than stroke. This was as far as the Guideline Committee considered they could go with the available evidence.

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						be of great benefit to unpaid carers to receive specific training in how to best support their loved ones living with the condition. A carer of a person with Parkinson's explains: *'Throughout the many years I have been my husband's full-time carer, the progression in severity and complexity of his various health conditions, (in which Parkinson's is a major player), has meant my caring role has had to alter and adapt to his ever increasing needs. All aspects of his wellbeing and safety rest squarely with me.'* We recommend that the wording is amended as follows: *'The relevant multidisciplinary team* ***must offer*** *family members and other carers needs-led training in care for people with conditions other than stroke. Training might take place in hospital or it may be more useful at home after discharge.'*	
	SH	Carers UK	Full	22	2	The contribution of unpaid care is invaluable and the health and care services would collapse without it. It is welcome that this contribution is recognised but many carers will not want to be referred to as a 'resource' and we would suggest rephrasing this. As well as encouraging NHS staff to involve carers to ensure they have the best understanding of the care needs of the person they care for. NHS staff also have an important duty of care to the carers themselves. This	Thank you for your comment. The Guideline Committee agreed and have reworded this recommendation, removing the term 'resource'. In wording this and subsequent recommendations as bout involving carers, the Guideline Committee has tried to reflect the valued contribution of carers to understanding about the person they care for as well as to recognise the needs and aspirations of carers for support in their own right. We have also made reference to this as part of the first challenge to implementation and have included a link to the NHS commitment to carers.

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						seems to have got lost in this recommendation and needs to be re-emphasised.	
	SH	Carers UK	Full	22	12	We are concerned that this recommendation implies **only** that the carer should be informed of their right to a carer's assessment. There is nothing in the guidance about ensuring that a carer's assessment is carried out, or at least arranged, before a person is discharged where the carer displays a need for one. Although it is assumed that the guidance will be read in conjunction with the Care Act 2014, it should still be reiterated in the guidance. There is also nothing in the guidance about care or support plans for the carer as part of the discharge process (if the carer's assessment has been carried out).	Thank you for your comment. On reflection the GC decided to remove this recommendation altogether. The aim of the guideline is not to simply reiterate legislation, but to add to it and since there was nothing specific, based on available evidence, that the GC wished to add this recommendation has been removed. We have referenced the Care Act in the introduction and in the context section of the guideline and are emphasising that the guidelines should be read in conjunction with the Care Act.
	SH	Department of Health	Full	22	13	Further information here would be helpful regarding Care Act – for example the relevant sections. May also be useful to reference that this carer's assessment should take place at the same time as the individual's assessment.	Thank you for your comment. On reflection the GC decided to remove this recommendation altogether. The aim of the guideline is not to simply reiterate legislation, but to add to it and since there was nothing specific, based on available evidence, that the GC wished to add this recommendation has been removed. We have referenced the Care Act in the introduction, context and implementation section of the guideline and are emphasising that the guidelines should be read in conjunction with the Care Act. We are currently considering implementation activities or tools might best help users of the guideline understand it in the context of the Care Act.
	SH	Yorkshire and Humber Commissioning Support	Full	22	16	This seems to imply that commissioners should be paying for training for carers and ensuring it is appropriate? Is this the intent? Does this include for social care staff also?	Thank you for your comment. The recommendation no longer refers to commissioners directly. The recommendation only refers to unpaid, family carers. See the 'terms used in this guideline' for a definition of 'carer'. These changes were carried out to clarify that the recommendation is about the need for training as opposed to who should fund it.

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	SH	Carers UK	Full	22 -23	21-2	The guidance states that needs-led training for carers/families should be offered when the condition is a stroke but should only 'consider' this for other relevant conditions. It is stated in the guidance that 'consider' is used where the quality of evidence is poorer or there is a closer balance between benefits and risks. However, where this training is going to be beneficial to a carer, it should be provided. In order to meet their duty to look at and assess families and what support they need to care, health practitioners will be identifying training of this type and other measures as necessary in order to discharge someone home effectively, if so they must be provided, regardless of the 'condition' the person might have.	Thank you for your comment. Recommendation 1.5.34 was based on evidence about the effectiveness and cost-effectiveness of training for carers of stroke patients. The Guideline Committee extrapolated these findings to develop a linked, weaker recommendation about providing training for carers of people with other conditions. That is why 'consider ' is used for recommendation 1.5.35.
	SH	Department of Health	Full	22	20	As above, it may be helpful to draw out other conditions that may require specific consideration such as dementia, learning disabilities, mental health conditions.	Thank you for your comment. The focus of the guideline was on general principles of transition and recommendations were only made on specific conditions where there was specific evidence, for example, stroke. The evidence concerned the value that caregivers of stroke patients attached to receiving information and support, including the practical and emotional aspects of providing care.
	SH	Cabinet Office	Full	22	12, 16	Civil society organisations provide vital support to carers, including through provision of respite breaks and peer support and befriending. Cabinet Office is currently funding seven pilot sites using social action interventions to test what works when providing support to carers.	Thank you for your comment. The Guideline Committee agrees that many civil society organisations provide vital support to carers and agreed to make a number of additional references to the voluntary sector throughout the guideline. We have also removed the reference to commissioners from 1.5.33 in order to address this issue.
	SH	Care and Repair England	Full	23	25+	Add Practical support with repairs and adaptations services such as Home Improvement Agencies	Thank you for your comment. The list of bullets against 1.6.1 was not intended to be comprehensive but instead to provide examples to illustrate the range of services that should be considered. We have added "suitable temporary accommodation and support for homeless people" to the list of bullets.
	SH	Parkinso	Full	23	1.6.1	We recommend that access to respite care	Thank you for your comment. The list of bullets against 1.6.1

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		n's UK				is included in the list of supporting services and is available for a person upon discharge from hospital. This would provide an essential element of support for carers of people with long-term conditions like Parkinson's, who provide full-time care. A 2013 Parkinson's UK membership survey, conducted by YouGov* found that a quarter of family members or carers surveyed were in full-time employment, with nearly six in ten not working at all. The survey also found that nearly a quarter of those in paid employment have had to reduce their working hours in order to look after someone with Parkinson's, and around 23% had of those who were not working had to give up work to care for a person with Parkinson's. Research* has also found that increases in stress-related symptoms in those caring for a person with Parkinson's were associated with the number of tasks required of a carer their own health conditions and their declining financial status. *A carer of a person with Parkinson's explains: 'Respite care is difficult to arrange even if you can afford the cost. My husband's consultant told me ten months ago to get a regular break myself. I haven't had any cooperation yet from the local*	was not intended to be comprehensive but instead to provide examples to illustrate the range of services that should be considered. Section 1.6 is about the wider supporting infrastructure. The need to consider respite care where the discharge plan involves support from family or carers is included in recommendation 1.5.31.

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						authority'. * YouGov/Parkinson's UK, *Survey of people with Parkinson's and their friends, family and carers*, 2013	
	SH	Yorkshire and Humber Commissioning Support	Full	23	5	This appears to imply that a multidisciplinary review will occur every 6 months. Would this be better determined based on the specific needs of the person, in line with person centred care?	Thank you for your comment. The training and support needs of the carer should be reviewed at the same time as the person's reviews take place. The Guideline Committee felt these would usually be every six months and annually, hence the example given here.
	SH	Department of Health	Full	23	8	1.5.38 – Worth also drawing out the role of the GP and their obligations towards patients, especially over 75s.	Thank you for your comment. The Guideline Committee did not agree to including a specific reference to the GP in this recommendation as it wanted to be clear that this contact immediately following discharge could come from a range of health and social care practitioners, depending on the particular circumstances.
	SH	Cabinet Office	Full	23	9	Volunteers can be utilised to maintain contact with the person, through both phone calls and visits, freeing up resources for social care practitioners. They can also help signpost the person to any other services they might benefit from, and provide a point of contact in case of an escalation of need.	Thank you for your comment. The Guideline Committee did not agree to the proposed changes to this recommendation. The evidence did not support the use of volunteers to carry out these tasks.
	SH	Yorkshire and Humber Commissioning Support	Full	23	9	Community based healthcare practitioners generally remain in touch while there is a clinical need, but this appears to imply that contact should be proactively maintained even after issues have been resolved. Is this really the intent as it this could have a significant impact on the workload of community based teams?	Thank you for your comment. The Guideline Committee agree. We have added 'as required' to this recommendation.
	SH	Cabinet Office	Full	23	20	It is key that the range of local services available in the community includes social action interventions: local health commissioners should support their provision by civil society	Thank you for your comment. We have changed this recommendation to "Ensure a range of local community health, social care and voluntary sector services are available to support people when discharged from hospital".

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						organisations, as they can harness the time and skills of those in the community to help complement public services. Mentioning this here would be a good opportunity to ensure commissioners are kept minded of this.	
	SH	Department of Health	Full	23	21	1.6.1 – We would draw out GPs and the voluntary sector. Potentially also district nurses, social services, housing services.	Thank you for your comment. We have changed this recommendation to "Ensure a range of local community health, social care and voluntary sector services are available to support people when discharged from hospital".
	SH	Yorkshire and Humber Commissioning Support	Full	24	21-23	Would it be beneficial to include social care providers in this?	Thank you for your comment. We have amended this recommendation to ensure all relevant staff are covered.
	SH	Care and Repair England	Full	24	1	Amend to 'kept up to date with the availability of local health, **housing** and social care services'	Thank you for your comment. This recommendation came from specific evidence about the problems that can occur when out of hours services such as GPs are not aware of the range of health and social care services in the local area. The Guideline Committee did not agree to extend this to housing.
	SH	Department of Health	Full	24	1	Ideally we should promote health and social care commissioners knowing about all care providers' capacity, especially given the push towards integration and the nature of local markets.	Thank you for your comment. We believe this would be beyond the scope of the guideline, although recommendation 1.6.3 does imply the importance of keeping up to date with changes in local markets.
	SH	Parkinson's UK	Full	24	1.7.1	As below, we recommend that a key part of training around hospital discharge processes should include requesting NHS Continuing Healthcare assessments, developing a clear understanding of when an inpatient may benefit from such an assessment and navigating the Continuing Healthcare process, which is widely acknowledged as overly complex.	Thank you for your comment. We have added in an additional bullet to 1.7.1 to cover health and social care assessments.
	SH	Cabinet	Full	24	3	Local health and social care services here	Thank you for your comment. The Guideline Committee agree

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		Office				should include reference to those provided by civil society organisations.	and we have now added reference to voluntary sector services in recommendation 1.6.3
	SH	Cabinet Office	Full	24	8	As well as health and social care practitioners being aware of third sector or civil society services, local health commissioners should also be aware of these services in order to ensure successful services are funded and sustained locally. In addition, the discharge coordinator in particular should be aware of the third sector or civil society services available, in order to include in discharge planning as appropriate. Reference to these would be helpful.	Thank you for your comment. Recommendation 1.6.3 covers all care providers, including GPs and out of hours providers. All guideline recommendations are for providers and commissioners. Recommendations in the section on 'Discharge Planning' do cover your point about the discharge coordinator and need for them to identify practitioners (from primary healthy, community health, social care, housing and the voluntary sector) who will provide support when the person is discharged.
	SH	Yorkshire and Humber Commissioning Support	Full	24	8	It would be helpful to define "third sector services" in the document – It is possible that not all the target audience will understand the terminology.	Thank you for your comment. There is a definition of 'voluntary sector' in the glossary of the short guideline. It includes third sector and civil society organisations.
	SH	Care and Repair England	Full	28	26+	**Research on the impact of housing interventions on transitions** We note that the guidance references one study which focuses on the role of housing support for homeless people and we suggest this is due to a lack of investment in primary academic research specifically focused on the impact of housing interventions on health and social care and specifically on transitions. There has been some research on falls reduction and on the impact of adaptations and equipment on costs to care and health and wellbeing which are referred to below and would impact on hospital admissions/readmissions. We also recommend that there should be more research in this field.	Thank you for the suggested resources. The evidence review underpinning this guideline used agreed search strategies and inclusion and exclusion criteria. They reflect both the scope of the guideline and the commitment to basing the recommendations on the best available evidence. According to these, the references you suggest would not have been included. The reasons are given below:

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						• genHome is a project developed by the College of Occupational Therapy to bring together and map out housing related research and evidence relevant to the needs of disabled and older people, and for this to be available within an accessible database. It is work in progress with its data base accessible by author only – see https://www.cot.co.uk/genhome and contact genhome@cotss-housing.co.uk • A report that looks at the implications for health and social care budgets of investment in housing adaptations improvements and equipment through an evidence review: Better Outcomes, Lower Costs, Frances Heywood and Lynn Turner, Office of Disability Issues, DWP 2007 http://webarchive.nationalarchives.gov.uk/20120305133112/http:/odi.dwp.gov.uk/docs/res/il/better-outcomes-report.pdf • A summary of the evidence for falls reduction including the impact of home hazards assessments produced by the College of Occupational Therapists and endorsed by NICE https://www.cot.co.uk/sites/default/files/commissioning_ot/public/Falls-prevention-and-management-Evidence-Fact-Sheet-June2015.pdf • The impact of effective provision of home equipment and adaptations on hospital discharge was identified in a report by the Audit Commission in 2000	This is not a systematic review and would therefore not meet our inclusion criteria on study type. This would not have been retrieved via our search strategies as it is a fact sheet and not empirical evidence. This was published before the cut off date for inclusion of 2003. This would not have been retrieved as it is a webpage and not an article or a report. This was retrieved but not included because it is not specifically about transitions between hospital and home.

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						and 2002 http://www.communityequipment.org.uk/wp-content/uploads/Fully-equipped-2000.pdf and Fully Equipped - assisting independence Audit Commission 2002 (Google for PDF) - Building Research Establishment (BRE) work that has modelled and quantified the health risk analysis of specific housing characteristics (such as hazards that reduce the risk of falls and illnesses (e.g. respiratory illness) https://www.bre.co.uk/page.jsp?id=3021 - The billion dollar question: embedding prevention in older people's services – 10 high impact changes Allen & Glasby J University of Birmingham (2010) http://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/publications/PolicyPapers/Policy-paper-8.pdf We propose new research to assess the impact of housing interventions on transitions for the reasons set out in our general comments. We believe housing to be an important factor in enabling people to remain out of hospital and more robust research would help to support the drive to greater integration of services including housing as set out in the Care Act and considered in our comment 17 below. 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	The Catch 22 project would not have been retrieved as this is a link to a campaign website and is not a report, article, empirical evidence.

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						work on projects that have practical application. The project is called Catch 22 (See http://careandrepair-england.org.uk/?page_id=205) Work already developing in this field includes the cost/ benefits of 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	
	SH	Older People's Advocacy Alliance OPAAL UK	Full	41	General	This section on effective communication should be broadened to give full consideration of independent advocacy. Giving a definition of advocacy would help this. Advocacy supports and enables people who have difficulty representing their interests, to exercise their rights, express their views, explore and make informed choices. OPAAL believes that there are specific circumstances where all individuals must have a right to the support of an independent advocate to ensure that their own interests and preferences are acknowledged and addressed. These services must be available to all older people who are: • At the point of discharge from hospital • Directly affected by a change in the management or running of their care service • At the point of accessing	Thank you for your comment. We have made reference to the importance of advocacy in a number of recommendations, for example in 1.1.2 and 1.2.3. Thank you for the examples of resources and case studies that could help practitioners. As part of our implementation work we will be actively encouraging organisations with relevant practice examples to submit these to the NICE database for shared learning and wider dissemination.

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						continuing care and community care services, and - At all reviews affecting care services in hospital and in the community. NICE ask for recommendations for resources that would support practitioners, we recommend: http://www.opaal.org.uk/Libraries/Local/1013/Docs/Resources/Advocacy%20Stories.pdf http://www.opaal.org.uk/Libraries/Local/1013/Docs/Resources/opaal%202009%20Speaking%20up%20to%20safeguard.pdf Our blog, which includes casestudies relating to transition between settings http://www.opaalcopa.org.uk and our website (see Resources) www.opaal.org.uk	
	SH	Older People's Advocacy Alliance OPAAL	Full	84	General	OPAAL is concerned by registered nurses admission that hydration and nutrition are neglected in the hospital admission process where there can be a	Thank you for your comments. The scope of the guideline does not cover all aspects of support and care received whilst in hospital but is concerned mainly with the points of admission and discharge. Rec 1.2.3 talks about the importance of understanding and

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		UK				lengthy wait for admissions from care homes into inpatient hospital settings. The documentation states that nurses are not able to advocate for patients owing to time pressures. OPAAL advocates for independent advocacy for older people, particularly when transitioning between care settings, which can be confusing and as identified here there is a risk that with no one to speak for them, older people are not heard. OPAAL resources identify strong outcomes where independent advocacy is engaged, see our book Every Step of the Way for details. The cancer advocacy services that we support, see particularly Jim and John's stories which highlight advocacy in action in hospital settings. http://www.opaal.org.uk/Libraries/Local/1013/Docs/Resources/Advocacy%20Stories.pdf Furthermore the documentation goes on to say older people with dementia are often under-triaged because they are not able to communicate their symptoms, this guideline should highlight specialist dementia advocacy,	continuing where possible usual daily routines (which may include routines around eating and drinking). 1.3.3 talks about personal profiles containing the persons needs and wishes and the importance of this information being passed to the admitting team. Thank you for the examples of resources that could help practitioners. We will consider these in our implementation work and will be encouraging organisations to submit relevant practice examples to NICE database for shared learning and wider dissemination.

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						although carers are noted as acting in an advocacy role many older people do not have carers, family or friends to provide support, and this support may not always be appropriate, the guideline should make clear that practitioners should know how to make a referral to a local advocacy service	
	SH	Older People's Advocacy Alliance OPAAL UK	Full	213	General	This guideline comprehensively sets out a wide range of circumstances in which there is evidence that older people's voices are either at risk of not being heard, or in some cases professionals admit older people are not able to communicate their wishes and staff are unable to provide support owing to time pressures. To this end OPAAL feels it is not enough for the recommendations on page 213 to suggest that a discussion with the patient prior to admission *might* cover offering independent advocacy support, this support should be offered actively in every case.	Thank you for your comment. Discussions about advocacy services will not be appropriate in all cases. The suggestions for discussions listed in recommendation 1.2.3 are all examples to illustrate the scope and range of the discussions that should take place. It is not intended to be a comprehensive list.
	SH	Royal College of Speech and Language Therapists	Full	312	8.10	Under glossary and abbreviations the document describes care plan. A care plan should be in a format which the patient can understand.	Thank you for your comment. The guideline will now signpost to the Think Local Act Personal definition of Care Plan which highlights service user involvement in creating the plan. Making information accessible and available in a format which is easy for the person to understand is an overarching principle of the guideline, hence recommendation 1.1.6, "Offer information in a range of formats, for example: • Verbally an in written format (in plain English)

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							- In other formats that are easy for the person to understand such as braille, Easy Read or translated material (see the Accessible Information Standard)"
	SH	City of York Council Adult Social Services	Short	General	General	We very much welcome this draft guidance on transitions between hospital settings and community or care home settings. Overall, the recommendations fit with our views about the best way of supporting people experiencing hospital admission and transition back home or to a care home. We are actively working with Health colleagues to address difficulties where care is not adequately coordinated between health and social care. Currently one of our major problems for both social care and health is the availability of care and support in people's own homes – lack of capacity in the home care system – despite many initiatives to address this. This is a problem for people being funded via Continuing Health care monies as well.	Thank you for your support. We recognise the problems you describe. Unfortunately it is not within the scope of NICE social care guidelines to make recommendations about the design or capacity of the local care and support market. However, you might find it useful to refer to the implementation section of the guideline.
	SH	Wirral Older People's Parliament	short	general	general	Question 1 We feel very strongly that local authority housing departments and local social landlords should be active parties in all health and well-being initiatives. There should be senior presence on Health and Wellbeing Boards. Locally, our integrated care teams in the community should have housing input. Professionals with a housing knowledge and background (possibly specialist social workers or Ots) should be involved in both hospital discharge teams and community teams. The needs of the older complex population, which would usually be assessed before hospital episodes, should include support in making suitable housing decisions	Thank you for your response to this consultation question. The Guideline Committee has tried to reflect in this guideline that the composition of the multi-disciplinary team involved in someone's care and support should reflect the needs, circumstances and aspirations of that person. The hospital- and community based multi disciplinary teams therefore now include 'housing officer' (see recommendation 1.3.7 and the definition of community based multi disciplinary team in 'terms used in this guidance') We have also highlighted the importance of housing, for example in recommendation 1.5.17, which now includes housing practitioner among those who may provide support following hospital discharge and. In the context section, a line has now also been added to emphasise that, in line with the Care Act the guideline covers health and health-related provision (including housing) and

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							other care and support.
	SH	Wirral Older People's Parliament	short	General	General	Question 2 .IT is the essence of this. Currently far too much valuable professional time is spent trying to communicate. With patient consent, all necessary medical and care information MUST be available as it happens to all professionals involved with the patient. The hospital updates on ward rounds and shift changes must be seen by the community team preparing for discharge. This will involve most localities in massive work on the different IT systems. It is currently happening here in Wirral. Patients and carers must have clear explanations that this will provide much better joined up care, and their records will NOT be sold to outside bodies!	Thank you for your response to this consultation question. The Guideline Committee highlighted effective communication as one of the key challenges for implementation of this guideline. We have identified some resources that may help practitioners in the implementation chapter. We note the concerns that you raise. The guideline recommends that communications protocols and procedure are in place from the point of admission (1.3.1) and we would expect these to apply information governance requirements to protect people's information.
	SH	Wirral Older People's Parliament	short	general	general	Question 3 Assessment at home before or after discharge. Whether the admission is planned or emergency, we fully support assessment at home with hospital assessment making as few long term recommendations as possible. We have some excellent examples locally of Age UK and others providing excellent "home from hospital" and general befriending services which appear to be invaluable. We would be interested in some research to properly assess the role and value of such voluntary organisations; to include the role of these volunteers in the actual re-assessments of need.	Thank you for your helpful response to this consultation question and for flagging a local service that you feel would merit research. We are aware that the role of the local voluntary sector is often highly valued by older people and hope this will be recognised in future research activity.
	SH	Wirral Older People's Parliament	short	general	general	Question 4 Proper integrated working between all the disciplines and organisations is the biggest challenge for all of the agencies and will have the biggest positive impact on patients, carers and finances. It involves extensive training of existing staff and all trainees. This is essential. It includes training on communication with patients and carers. We strongly support	Thank you for your helpful response to this consultation questions. We have reflected your points in the three implementation challenges and will take account as we consider possible activities and tools to support implementation of this guideline. The 'implementation challenges' section currently appears just after the recommendations and the 'terms used in this guideline'.

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						the production of far more simple informative leaflets about medical conditions, self-help procedures for all of them, local services to support them, and for every discharge patient and carers a personalised list of a few relevant supports or phone numbers. This is relatively cheap and invaluable to most patients and their families. The impact of "Hello my name is…" on patient care locally has been enormous, and has cost very little. All improvements towards integration and communication with patients should help reduce admissions. We would also recommend that pharmacists are an integral part of community integrated teams.	
	SH	Wirral Older People's Parliament	short	general	general	Question 5. We are convinced that users will benefit greatly as the move towards integrated community teams with a named care coordinator develops. We know from local developments, that simple, informative leaflets about conditions and services can be very reassuring to patients and carers. If community services can improve quickly in the way they are delivered , people will have much more confidence that hospital is not the best answer in many situations.	Thank you for your response to this consultation question. We will take account of your response as we consider further implementation support.
	SH	Parkinson's UK	short	General	general	Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly. We would like to hear your views on these questions: 1. The Care Act 2014 sets out new housing duties for local authorities to promote integrated health and care. How can local authorities and housing providers better help to assist the type of transition this guideline describes?	Thank you for your responses to these consultation questions. We have noted your points about the importance of information

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						Parkinson's UK strongly believes that an integrated service will lead to better outcomes for people with Parkinson's. An example of this is our support for the Health and Social Care (Safety and Quality) Act 2015 and its aims to establish the use of a common identifier (such as an NHS number) to facilitate better information sharing across health and social care organisations. 2. How can technology be better used to assist communication between hospital and community or care home settings as described in this guideline. We believe that technology that would assist with sharing of patient data would be beneficial to patients and can also improve services. Responsible sharing of patient data within and across health and social care services can provide great benefit for service provision and help to give better care and treatment for people with Parkinson's, as sharing information leads to better coordinated care. This could mean that staff in community and hospital settings are more aware of a person's condition, how it impacts them and the status of supporting services, enabling a smooth transition between care settings. It is important that this is done safely and securely. Use of patient data should be fully communicated to the public so that they are aware of how their data is being used, who has access to it, and given the opportunity to withdraw their data from being shared if they	sharing in accordance with good information governance standards to achieve better coordinated care and support. The Guideline Committee agreed that good systems, protocols and procedures to support communication and information sharing are essential to enable implementation of this guideline. We have highlighted this as the second implementation challenge and identified some resources that may be helpful to practitioners. The 'implementation challenges' section currently appears on page 17 of the short guideline, just after the recommendations and the 'terms used in this guideline' section. Thank you for your comment on this consultation question and

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						wish. Therefore, should be provided to health professionals to ensure they handle patient data appropriately. 3. What are your views on the draft research questions (section 3 of the short version)? Do you know of any research currently in progress that overlaps with these research questions? We agree that further research into the areas identified would be of benefit, but we particularly welcome the acknowledgement of the value of investigating the potential impact of training for hospital and social care practitioners further. Although we are not aware of any research in this area at present, we agree that studies which provide qualitative data from home care commissioners and providers around experiences and perceptions of training would be of great value. One piece of research that is currently being funded by Parkinson's UK that may be of relevance, is a piece of research to identify the most important factors that affect quality of life for people with Parkinson's in care homes – who often have complex needs. The research will use interviews and comparisons between care services to explore who these people are, their needs, quality of life, and how and why they came to be in care. 4. Which areas will have the biggest	support for research in this area. Thank you for your response to this consultation question, highlighting the particular impact on individuals and carers if all practitioners conducted work in a more person-centred way and recognised the effect on carers, We will take account of this and the factors you suggest will help users to overcome the challenges as we consider additional activities or tools to support implementation of this guideline.

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						impact on practice and be challenging to implement? Please say for whom and why. For people with Parkinson's, immediate assessment and care planning upon entering hospital, as recommended in 1.3.9 will potentially have the greatest impact on improving practice. This is because it could ensure smooth transition from inpatient and community social care, if a person's social care needs are identified and an appropriate care plan can be arranged prior to discharge. However, this will also be challenging to implement, because it will require all healthcare professionals concerned with a person's care, both in hospital and in the community, to be familiar with NHS Continuing Healthcare and the assessment process. We discuss this further in comment 10. Other recommendations which will have a significant impact on practice relate to carers, particularly 1.5.36-1.5.37, which require healthcare professionals to consider offer training for carers, as well as reviewing their training and support needs regularly. These will, if implemented properly, make a significant difference to the lives of unpaid carers, who can find the emotional, psychological and physical impact of their caring responsibilities difficult. However, these recommendations may also be among the more difficult to implement, because carers may not recognise themselves as providing a 'caring' role and may not be willing to accept support for this reason. A carer of a person with Parkinson's explains: 'I	

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						find it hard to ask for help from other people. That's one big advantage of belonging to Parkinson's UK – meeting other people and talking means I'm much more aware of what's out there.' 5. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) Effective, preventative emotional and psychological support for carers and people with Parkinson's may help them understand their situation, overcome challenges and ensure that they are not overwhelmed. Parkinson's UK has a range of supporting services, including peer-support, information resources, a helpline and a network of local groups for people with the condition and carers. Signposting to Parkinson's UK services where appropriate may therefore help those living with Parkinson's overcome some of these challenges.	
	SH	Marie Curie	Short	General	General	Marie Curie is the UK's leading provider of care and support for people affected by terminal illness. Many people living with a terminal illness will need social care, especially as they approach the end of their life. The Nuffield Trust's 2010 report 'Social care and hospital use at the end of life' found that 30 per cent of people had some form of local authority funded social care service in the 12 months prior to their death. For older people this proportion exceeded 40 per cent. People living with terminal illness often also	Thank you for your support. We agree about the importance of supporting people with end of life care needs throughout transitions between hospital and home, including care homes and hospices. For this reason, the evidence review used a specific question focussed on this population. In the Guideline, there is a dedicated section on discharge planning for people with end of life care needs (1.5.22 – 1.5.24). There are also a number of recommendations to ensure that people's preferences about end of life care are understood and communicated with all those involved in the transition process, for example in recommendations 1.2.3 and 1.6.4 . The Guideline Committee made all the recommendations they felt they had evidence to support.

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						have high levels of hospital use. The King's Fund recent report 'Better Value in the NHS' cites a wealth of evidence which shows that improving coordination and communication between hospital and community care providers would improve experiences of care and reduce costs. Marie Curie is therefore pleased that end of life care needs are considered throughout the draft guidelines. However, we believe further clarification and additions are needed to strengthen this guidance for the benefit of people living with terminal illness and those approaching the end of their life.	Finally, you may be interested in NICE's Care of the Dying Adult guideline, which is in development and due to be published in December 2015.
	SH	Marie Curie	Short	General	General	Consultation would have been more straightforward to complete if draft guidance contained line numbers rather than section numbers when it is stipulated that line numbers are used in the response.	Thank you for your suggestion, which will be fed back to the editors.
	SH	Royal College of Surgeons	Short	General	General	1. *The Care Act 2014 sets out new housing duties for local authorities to promote integrated health and care. How can local authorities and housing providers better help to assist the type of transition this guideline describes?* • Increase speed of funding decisions • Step down facilities available at short notice whilst longer term plans are made	Thank you for your response to this consultation question. We note your points about the need for quick decision making and availability of resources at short notice. Due to its remit, NICE is unable to make recommendations about specific types of funding; however, we recognise that health and social care funding in general can be a factor in preventing timely transition. In light of yours and other stakeholder comments, the Guideline Committee discussed the issue of timely funding assessments and were in agreement about the need to reflect it in the guideline. The Guideline Committee also felt that reference should be made to assessments for funding ongoing social care. They reached a consensus that 'assessments for health and social care eligibility' should be added to the list of factors that might prevent a safe, timely discharge from hospital (1.5.13). They also added 'how to arrange assessments for eligibility for health and social care' to the list of areas related to hospital discharge in which staff are trained (1.7.1).

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						Many delays occur whilst funding is sought by commissioners on a case by case basis	
	SH	Royal College of Surgeons	Short	General	General	2. *How can technology be better used to assist communication between hospital and community or care home settings as described in this guideline.* • Linking discharge letters with EPR and GP practice NHS emails. Many hospitals may send out letter within 24 hours, but rely on postal service • Availability of a telephone number to call re queries about health and also clear contact for social issues Availability of Telecare/telehealth services and telephone follow up	Thank you for your response to this consultation question "Ensuring health and social care practitioners communicate effectively" is one of our stated challenges for implementation. We have also identified resources that may help practitioners to support implementation.
	SH	Royal College of Surgeons	Short	General	General	3. *What are your views on the draft research questions (section 3 of the short version)? Do you know of any research currently in progress that overlaps with these research questions?*	Thank you. We have noted that you have no comment about the draft research recommendations.

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						No comment	
	SH	Royal College of Surgeons	Short	General	General	4. *Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why.* • Better patient and family involvement and support for informed decision making. • Availability of clear advice on discharge on who to contact about concerns or queries • Limiting the number of times the patient is moved between wards has during admission • Clear advice on follow up arrangements and other referrals such as rehabilitation Particular care taken with those who require support for essential care and who have no family or other social support	Thank you for your suggestions.. Your reponses are reflected in our 'challenges for implementation' section. Firstly, 'improving understanding of person-centred care' which highlights the importance of patient and family/ carer involvement in care planning decisions. Another of our challenges for implementation is: 'changing how community- and hospital-based staff work together to ensure coordinated, person-centred support'. This challenge aims to create a more efficient and cost-effective use of resources; such as avoiding 'revolving door admissions'.
	SH	Royal College	Short	Gene	Gen	5. *What would help users*	Thank you for your response to this consultation question and the helpful practice examples to illustrate. We are encouraging

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		of Surgeons		ral	eral	*overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.)* A Single named co-ordinator and number for patients and family to call if required to manage all potential issues and act as a liaison with different stakeholders e.g. in Torquay where single number allows access to social/ equipment and medical advice and has been proven to reduce admissions	organisations with relevant practice examples to submit them to the NICE data base for shared learning and further dissemination.
	SH	Sense	Short	General	General	Following the release of The Accessible Information Standard (SCCI 1605) there are some additions that should be made to bring this guideline in line with the obligations that Health and Social Care Organisations will have to follow. Under the Standard, Health and Social care providers will have to identify, record, flag, share and meet any information or communication needs of those who access their services with communication difficulties due to sensory loss and/or learning disabilities. More information and detail can be found on the NHS England website. The following comments highlight where we think additions should be made in relation to this.	Thank you for highlighting the Accessible Information Standard. We have now made reference to the Accessible Information Standard in recommendation 1.1.6 about offering information in a range of formats.
	SH	Crisis	Short	General	General	Question 5: examples of good practice are: Kings Health Partners Pathway Project. The team provides advice about homelessness, health and housing law and supports people by	Thank you for your response to this consultation question. We are keen to encourage organisations with relevant practice examples to submit them to NICE for shared learning and wider dissemination. We have added reference to the

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						providing a wide range of practical support and assistance. The pathway approach has shown a 30% reduction in annual bed days for homeless patient admission. Tower Hamlet's and the London Hospital's "Routes to Roots" approach which prevents patients being discharged to the streets. Streetmed- - a nurse led project that combines the skills of nursing and homeless outreach to help clients overcome barriers to healthcare. Hospital Discharge pilot fund – In May 2013 the Government set up a £10 million hospital discharge pilot fund for voluntary sector organisations working in partnership with the NHS and local government, to improve hospital discharge process for people who were homeless. Homeless people who received help from the pilots reported higher standards of care with non-judgemental treatment and they experienced improved support throughout and after their time in hospital.	evaluation of the Hospital Discharge pilot you refer to in the implementation chapter.
	SH	Crisis	Short	General	General	Crisis welcomes this guideline from NICE but we would emphasise that homelessness should be a theme that runs through the guideline rather than an occasional "add on" to a list of specific areas of vulnerability. Homeless people have a distinct set of needs that must be addressed. Research for Crisis[3] has found that homeless people are more likely to die young, with an average age of death of 47 years old and eve lower for homeless women at 43, compared to 77 for the general population, 74 for men and 80 for women. Drug and alcohol abuse are	Thank you for your support. The Guideline Committee agrees with you about the importance of supporting homeless people throughout transition to and from hospital. They did not intend to suggest homeless people are an 'add on' but were restricted in the number and nature of recommendations they could make about this population because of the relative lack of evidence in this area. Although there is evidence about the health and care and support needs of homeless people, only a limited amount of evidence of moderate quality was located which specifically relates to homeless people during transition to and from hospital.

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[3] Crisis (2012) *Homelessness Kills*

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						particularly common causes of death amongst the homeless population, accounting for just over a third of all deaths. Being homeless precludes a healthy lifestyle. Poor sleep quality, inadequate diet, difficulty in maintaining personal hygiene, and problematic access to health care and maintaining a treatment regime can lead to sub-optimal health.	
	SH	United Kingdom Homecare Association	Short	General	General	The guidelines include very detailed instructions in some instances, such as detailing what should happen in a ward handover meeting between shifts at s1.4.2 – p13, whilst endeavouring to create a strategic disposition for the multi-disciplinary management of transition care**:** we are concerned that the minutiae of detail may undermine the bigger picture which could usefully focus on structures, processes and outcomes at the system-planning and service-design level rather than defining what nurses should do between shifts	Thank you for your comment. The Guideline Committee developed recommendations where they felt there was evidence of sufficient strength and quality to do so. In some cases the evidence indicated that strategic action should be taken to improve transitions whereas other evidence provided the opportunity to make specific recommendations for action at the practice level.
	SH	Macmillan Cancer Suppport	short	general	general	Macmillan recognises that more people than ever are living with and beyond cancer. In turn, these people need support during and after treatment that meets their ongoing and varied needs, so they can live with cancer as a long-term and fluctuating condition. Surviving cancer is not always the same as living a full and healthy life. There are often long-term consequences of treatment that require ongoing care and support. At least 500,000 people in the UK are facing poor health or disability after treatment for cancer, which is one in four of the current population of people living with cancer.(Macmillan July 2013. Throwing light on the consequences of cancer and its treatment).	Thank you for your response and all the information provided. We will consider using your examples of pilots in our implementation work.

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						This places an increased and varied demand on health and social care services, as each individual's needs are different and will vary at different stages of treatment. While there is a continued need for specialist health services and interventions, there is also a growing role for community based services. However, there is **currently not enough capacity in community based services** to meet demand. The number of qualified district nurses in England has dropped 47% in the past decade, to just 6,656 in 2013[4]and district nurses have a higher average age than other nurses. With the appropriate clinical, emotional, financial and practical support from health and social care professionals, carers and volunteers, many more people with cancer could self-manage their own conditions. Macmillan is committed to providing support at care transitions and that this is undertaken in partnership with the person affected and in holistic way; but our pilots have highlighted the considerable capacity shortfall in the health and social care system to undertake assessment and deliver co-ordinated care plans. Nurse-led support has become increasingly important in cancer care, particularly in terms of educating patients and providing the psychosocial support they need throughout their	

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[4] RCN, Survey of district and community nurses in 2013

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						'cancer journey'. This type of support has already proven valuable in cancer patient follow-up care. A lot of this type of support is currently delivered by clinical nurse specialists and other cancer specialists, yet not everyone diagnosed with cancer has access to a CNS, with people with rarer cancers and in certain geographic areas more likely to miss out. While there is a need to continue investing in specialist posts, and addressing supply and retention issues, simply filling the gap with more of the same will not be sustainable in the long term. Therefore, Macmillan has piloted four new roles to explore ways of using skill-mix teams to deliver tailored and more efficient care for people affected by cancer, to address the specialist gap. You can read the full report from phase 1 of the pilot here. One-to-one support for people living with cancer is best understood as a service that supports an individual's journey across the whole cancer pathway, based on the intensity and nature of their needs at each stage, using a team with a skill-mix appropriate to the level of need. It is a service that aims to improve quality of care and patient experience and outcomes, while using resources in a more cost effective way. The aim is that everyone with cancer will have access to one-to-one support - which may not always come from the same person - but will be appropriate for their level of need at each stage of the cancer pathway. This approach will	

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						implement person centred supported self-management and holistic care, delivering improved experience and quality of life for people affected by cancer. **The Macmillan support worker role** The most successful role piloted in phase 1 was that of the Macmillan support worker. Early indications are that these roles help CNSs to manage a bigger caseload by taking on some of the less clinical and less specialized areas of work, as well as offering patients a single point of contact and continuity. Many of the support workers roles for stage 1 of the pilot are being sustained and rolled out. A strong economic case is building for the establishment of support workers, as they release specialist capacity and community posts for more face to face and complex patient care. This is borne out by examples in Scotland, UCLH, and Southampton where support workers have released between 30-50% of more qualified staff time. **This is by providing a first point of contact for patients, supporting the implementation of the Recovery Package (including completion of holistic needs assessments and designing and delivering well being events**) and supporting redesign of patient follow up. Evidence from phase 1 shows that support workers can: 1 Improve patient experience	

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						• The overall quality of support provided by Macmillan One- to-One workers was rated an average of 9.3 out of 10 compared with an average of 7.7 for other health care professionals • 94% of respondents felt that Macmillan One- to-One workers understood their needs completely or a lot • 88% of respondents reported that they felt that their Macmillan One-to-One worker understanding their needs had a direct impact on the quality of their care. 2 Support care co-ordination and continuity, including signposting to other support • 85% of respondents felt that their Macmillan One-to-One worker had helped other healthcare professionals to understand their needs 'completely' or 'a lot' 3 Directly provide and network with other services - many of the one-to-one support services are directly supporting people to address concerns about tiredness/exhaustion/fatigue, along with emotional and psychological support, but referring individuals on to other services (where they exist) for information, practical and financial support. 4 Allow CNSs and other specialists to	

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						maintain a bigger caseload by taking on many of the less clinical tasks and triaging calls to the CNS, freeing up specialist time. The job description for the Support Worker role may serve as a useful starting point for development of a discharge coordinator role.	
	SH	NHS Providers	short	general	general	Our members fed back that overall they feel the guidelines are well-intentioned and generally helpful.	Thank you for your support.
	SH	SeeAbility	Short	General	General	SeeAbility welcomes the opportunity to respond to this consultation on the draft guideline recommendations. SeeAbility is the national charity that exists to support people with sight loss and multiple disabilities. SeeAbility's work with adults with sight loss and learning disabilities includes: • Providing personalised support services in people's own homes; supported living schemes and residential care homes across southern England • Supplying training, advice and information resources. Our services include therapeutic support such as speech and language therapy, rehabilitation, physiotherapy and assistive technology. As such our comments are based on direct experiences of the systems that exist to support people with sight loss and multiple disabilities have a safe and smooth transition home from hospital.	Thank you for your comment and the information provided.

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						We are pleased that the likelihood of sensory loss amongst people with learning disabilities highlighted in page 8 of the introductory guideline and an emphasis on communication in the format that people need (paragraph 1.1.5) Our experience is that effective discharge can be a postcode lottery. Where an Acute Liaison/Learning Disability Nurse post is in place within hospitals this can support relationship building in advance/outside any crisis situation and can then support as/when admissions occur. There is surprisingly no mention of the importance of these posts in the process of transition. Rather the guidelines seem to focus on dementia, stroke and end of life care. We believe there needs to be equal emphasis on the needs of those with learning disabilities. Perhaps because of this, there is no mention of the importance of advocacy for those who would benefit from this in terms of discharge planning and smooth transition. This needs to be rectified in the final guideline. There will be a link between this guideline and the proposed draft service model for people with learning disabilities and/or autism and challenging behaviour, which focusses on avoiding inpatient admissions and unnecessary length of stays in inpatient settings and has a particular emphasis on good communication and advocacy. We think it would be helpful to cross refer to this work. For more see: http://www.england.nhs.uk/wp-content/uploads/2015/07/ld-draft-serv-mod.pdf.	Thank you for your suggestion. In light of this, recommendation 1.1.2 in the overarching principles now states that support to access advocacy may be part of identifying and supporting people at risk of less favourable treatment. Thank you. There will be a link between this and a number of NICE guidelines and this will be reflected in the NICE pathway on transitions.

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						We welcome the recognition of informal carers in the draft guideline, although we feel their role is underemphasised given the expectations often placed upon them on discharge. We would also like to see more emphasis on working with formal care providers to ensure that people are not unnecessarily delayed in hospital or are discharged without providers input and involvement early on. We have had some very good experiences of reablement teams in supporting people back to our services but have also experienced attempts made for unsafe discharge of people to our services who are in need of a heightened level of support. Disputes also take place over funding while the person is in hospital that delays and protracts the process.	The role of carers was seen by the Committee as an important aspect of effective transitions and to this end there are sections dedicated to involving carers in the guideline – 'involving carers' (1.5.29 – 1.5.31) and 'support and training for carers' (1.5.32 – 1.5.35).. It is also an overarching principle that subject to the person's consent, families and carers should be involved in discussions about care being given or planned and that they are in regular contact with the practitioners involved in the transition to and from hospital. In terms of working with formal care providers to ensure transfers from hospital are not delayed, the Guideline Committee believes this is addressed though recommendations such as 1.3.8 stating that the hospital- and community based multi-disciplinary teams should work together to provide coordinated discharge. In addition, the discharge coordinator should identify practitioners (from primary health, community health, social care, housing and the voluntary sector) to provide support for the person following discharge. Recommendation 1.5.18 in the final guideline also states that the discharge coordinator should discuss the need for a specialist equipment and support with primary health, community health, social care and housing practitioners as soon as discharge planning starts. This recommendation also states that the discharge coordinator should 'ensure any essential specialist equipment and support are in the place at the point of discharge'.
	SH	Airedale NHS Foundatio	Short	General	general	There is no recommendation around the Continuing Health process and the categorisation of Delayed Transfers of Care,	Thank you for your suggestion. In light of yours and other stakeholder comments, the Guideline Committee discussed this issue and was in agreement about the need to include it.

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		n Trust				which is an area that does cause delays for the patient at times.	The Guideline Committee also felt that reference should be made to assessments for funding on-going social care. They reached a consensus that 'assessments for health and social care eligibility' should be added to the list of factors that might prevent a safe, timely discharge from hospital (1.5.13). They also added 'how to arrange assessments for eligibility for health and social care' to the list of areas related to hospital discharge in which staff are trained (1.7.1).
	SH	Airedale NHS Foundation Trust	Short	General	general	Example of good practice, the Trust is developing a shared patient record system with the GP, Systemone, enabling the sharing of information in a timely fashion. There are intentions for the Local Authority to also be using this same electronic record system.	Thank you for your comment. We will consider your example in our implementation work.
	SH	Airedale NHS Foundation Trust	Short	General	general	Example of good practice, we have implemented a single point of access for intermediate care services, used by both community staff and hospital staff, the Hub manages the intermediate bed base. This is staffed by health and local authority staff.	Thank you for your comment. We will consider your example in our implementation work.
	SH	Stockton-on-Tees Borough Council	Short	General	General	It's pleasing to note that NICE are providing guidelines for the transition between inpatient hospital settings and community or care home settings for adults with social care needs. It is also pleasing that there are a number of references to housing detailed within the document and the need for early discussions between colleagues across different disciplines.	Thank you for your support.
	SH	Stockton-on-Tees Borough Council	Short	General	General	Would it be possible to emphasise that when 'homeless' is identified (or potential homelessness) that contact be made with the named Local Authority Homelessness contact as soon as possible (even if it is	Thank you for your comment. Recommendation 1.5.28 of the final guideline states that where a person is identified as being homeless, the discharge coordinator should liaise with the local authority housing options team to ensure the person is offered help and advice.

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						only a 'flag' at any early stage). Linked to point 10 above.	
	SH	Action on hearing loss	Short	General	General	Action on Hearing Loss is the charity formerly known as RNID. Our vision is of a world where deafness, hearing loss and tinnitus do not limit or label people and where people value and look after their hearing. We help people confronting deafness, tinnitus and hearing loss to live the life they choose. We enable them to take control of their lives and remove the barriers in their way. We give people support and care; develop technology and treatments and campaign for equality. Our response will focus on key issues that relate to people with hearing loss. Throughout this response we use the term 'people with hearing loss' to refer to people with all levels of hearing loss, including people who are profoundly deaf. We are happy for the details of this response to be made public. General Comments Action on Hearing Loss welcomes the NICE guideline on transition between inpatient hospital settings and community or care home settings for adults with social care needs. We support the broad aims of the guideline to improve the experience of adults with care and support needs when they are moving in or out of hospital from community or care home settings. Poor transitions planning can lead to inappropriate care and deterioration in health and wellbeing. It is vital that health and social care practitioners consider the communication needs of people	Thank you for your comments and for all the useful information provided.

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						with hearing loss when planning transitions between care settings. Hearing loss is a long term condition which affects more than ten million people in the UK, about 1 in 6 of the population. The prevalence of hearing loss increases with age. Over 71.1% over 70 year olds have some form of hearing loss, meaning that most older people in hospital and care settings are likely to have hearing loss . Without treatment, people with hearing loss may find it difficult to communicate with others and are at greater risk of developing other health problems. Being unable to communicate properly can lead to a loss of confidence in social situations, reduced social activities and feelings of social isolation . People with hearing loss are more likely to develop paranoia, anxiety and other mental health issues – for example evidence shows that hearing loss doubles the risk of developing depression . Hearing loss has also been associated with more frequent falls , diabetes , stroke and sight loss . Evidence suggests that up to 40% of those with a learning disability have some level of hearing loss, and that this often goes undiagnosed or is misdiagnosed There is also strong evidence of link between hearing loss and dementia. Research shows that people with mild hearing loss are almost twice as likely to develop dementia compared to people with normal hearing. The risk increases	

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						three fold for people with moderate hearing loss and fivefold for people with severe hearing loss . Recent evidence suggests that hearing aids may reduce these risks. Underdiagnosis of hearing loss may lead to communication difficulties and a misdiagnosis of dementia. Dementia may appear worse than it is due to undiagnosed hearing loss . Hearing loss should be diagnosed and treated at the earliest opportunity to enable people with hearing loss to communicate well, to allow the effective diagnosis and management of other conditions, and to avoid deteriorating health and independence. Research shows that people wait on average ten years before seeking help for their hearing loss. When people eventually do seek help, GPs fail to refer up to 45% people with hearing loss for a hearing assessment. Hearing aids are most effective when fitted early. People with severe hearing loss find it more difficult to adapt to hearing aids . Timely access to hearing aids remove barriers to communication and enable people with hearing loss to communicate with friends, family and health and social care professionals. Hearing aids have also been shown by numerous studies to improve quality of life . Hearing aids reduce the risk of social isolation and depression , and new evidence suggests they reduce the risk of dementia . When planning transitions between care settings, it vital that health and social care practitioners consider the communication needs	

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						of people with hearing loss. Most importantly, the guideline must make reference to: - NHS England's recently launched Accessible Information Standard which sets out what adjustments people with hearing loss should expect when accessing health and social care. The standard, which is mandatory from from 31st July 2016, provides clear guidance on GPs, hospitals and social care providers must do to make their services accessible for people with hearing loss. It ensures people with hearing loss understand the information they are given and can participate fully in treatment discussions. In the context of transition planning, health and social care services must ensure that communication needs are included in referral and discharge procedures both within and between organisations. - NICE's quality standard for the mental wellbeing of older people in care homes which states social care managers and practitioners should be alert to the early signs of hearing loss, test for hearing loss, record instances of hearing loss and also be aware of the GP referral pathway for assessment and treatment. Questions 1. The Care Act 2014 sets out new housing duties for local authorities to promote integrated health and care. How can local authorities and housing providers better help to assist the type of transition this guideline describes? The provision of assistive equipment such as	Thank you for highlighting this. As a result, we have now made reference to the Accessible Information Standard in the overarching principles of the guideline.

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						amplified telephones, personal listeners or vibrating/flashing light smokes alarms or doorbells can support people with hearing loss in the home and prevent further deterioration in health and wellbeing. Under the Care Act 2014, local authorities have a duty to provide community equipment up to the value of a £1000, but the availability of this equipment and other support from local authorities should be promoted, as many people do not know it is available. Local authorities and housing providers also have separate duties under the Equality Act 2010 to make reasonable adjustments for people who have substantial difficulty accessing their services. Action on Hearing Loss has produced guidance for local authorities and housing providers on how to make their services accessible for people with hearing loss. It includes information and advice on staff training, adaptions for the home and suitable contact methods for people with hearing loss. For more information, please see our website http://www.actiononhearingloss.org.uk/about-us/wales/campaigns-wales/supporting-people-with-sensory-loss.aspx	Thank you for your response to this consultation question. We will draw upon this – including the link to the helpful information about your practice guidance - as we consider priorities for activities and tools that can support implementation of this guideline.
						2. How can technology be better used to assist communication between hospital and community or care home settings as described in this guideline.	
						3. What are your views on the draft research questions (section 3 of the short version)? Do you know of any research currently	Thank you for your suggestion. We acknowledge that this is an area that would benefit from further research. However, the Guideline Committee can only make research

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						in progress that overlaps with these research questions? Given that most people over 70 have hearing loss (71%), only a third of people who could benefit from hearing aids has them, and many people face issues accessing health and social care services, we suggest a research question should be added on the impacts of improving the identification and diagnosis of hearing loss as well as ensuring health and social care settings are accessible for people with hearing loss. The steps set out in this response would make a big difference to the health outcomes, quality of life, and independence of large numbers of older people, but their full impact is not well quantified. In particular, the full cost savings to health and social care services have not been researched, but they are likely to be huge. 4. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. The recommendations on Person Centred Care (Recommendations 1.1.1 – 1.1.3) will improve the planning of transitions between care settings for people with hearing loss and ensure they are able to participate fully in decisions about their care. We welcome the inclusion of “people with communication difficulties” in the list of examples of people at risk of less favourable treatment or less access to services. Under NHS England’s recently launched Accessible Information Standard , which is mandatory for all NHS and adult social care services, care staff	recommendations in response to gaps in evidence that have been identified through the evidence review. Research recommendations were prioritised by the committee in response to gaps identified in the evidence. Thank you for your response to this consultation question. Your points echo the Guideline Committee’s and we have added reference to the Accessible Information Standard both within the recommendations at and within the implementation chapter Thank you for your helpful response. Recommendation 1.1.6 now directly refers to the Accessible Information Standard, and it is also referred to in the implementation chapter. We will draw upon the information you provided as we consider plans for activities and tools to support implementation of the guideline.

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						must identify needs, take action to meet them and make arrangements for communication and information in alternative ways. The Accessible Information Standard provides extensive guidance on recording, flagging and meeting communication needs. If the guideline is to be effective, it is vital that the Accessible Information Standard is properly implemented and enforced. 5. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) Action on Hearing Loss has produced extensive guidance on what hospitals can do to make their services accessible for people with hearing loss. The 'Caring for older people with hearing loss' project found that simple steps such as ensuring hearing loss is recorded in a patient's care record and staff training on communicating with people with hearing loss and hearing aid maintenance enabled better communication between staff and patients and improved the care of older people in hospital. The project recommended that each NHS Trust should produce a hearing loss pathway to screen people for hearing loss and refer them to treatment if they do not have hearing aids. Other recommendations included the provision of personal listeners to improve communication and proper processes and brightly coloured hearing aid storage boxes to reduce the number of lost hearing aids and ensure hearing aids are used.	

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						For more information please see our 'caring for older people with hearing loss' nursing practice toolkit http://www.actiononhearingloss.org.uk/supporting-you/gp-support/nursing-toolkit.aspx and our guidance for GPs http://www.actiononhearingloss.org.uk/supporting-you/when-you-need-to-see-a-gp.aspx	
	SH	Action on hearing loss	Short	General	General	Action on Hearing Loss. (2011). Hearing Matters. www.actiononhearingloss.org.uk/hearingmatters [2] Gopinath et al (2012). 'Hearing-impaired adults are at increased risk of experiencing emotional distress and social engagement restrictions five years later'. Age and Ageing 41(5): 618–623; Monzani et al (2008) 'Psychological profile and social behaviour of working adults with mild or	Thank you for the suggested resources. The evidence review underpinning this guideline used agreed search strategies and inclusion and exclusion criteria. They reflect both the scope of the guideline and the commitment to basing the recommendations on the best available evidence. According to these, the references you suggest would not have been included. The reasons are given below: This would not have been retrieved because it is not empirical evidence. This was not retrieved because there is no explicit mention of transitions between in-patient hospital and community settings. This was not retrieved because there is no explicit mention of transitions between in-patient hospital and community settings.

ID	Type	Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
						moderate hearing loss'. Acta Otorhinolaryngologica Italica. 28(2): 61-6; Arlinger (2003). 'Negative consequences of uncorrected hearing loss – a review'. InternationalJournal of Audiology 42(2): 17-20 [3] Cooper (1976) 'Deafness and psychiatric illness'. British Journal of Psychiatry 129: 216-226; Saito et al (2010) Hearing handicap predicts the development of depressive symptoms after three years in older community-dwelling Japanese. Journal of the American Geriatrics Society 58(1): 93-7; Monzani et al (2008) Psychological profile and social behaviour of working adults with mild or moderate hearing loss. Acta Otorhinolaryngologica Italica 28(2): 61–66; Eastwood et al (1985) Acquired hearing loss and psychiatric illness: an estimate of prevalence and co-morbidity in a geriatric setting. British Journal of Psychiatry 147: 552–556 [4] Lin and Ferrucci (2012) Hearing loss and falls among older adults in the United States. Archives of internal medicine 172.4 (2012): 369-371	This was not retrieved because there is no explicit mention of transitions between in-patient hospital and community settings. This was published before the cut-off date for inclusion of 2003. This was not retrieved as there is no explicit mention of transitions between in-patient hospital and community settings. This was not retrieved as there is no explicit mention of transitions between in-patient hospital and community settings. This was not retrieved as there is no explicit mention of transitions between in-patient hospital and community settings. This was not retrieved as there is no explicit mention of transitions between in-patient hospital and community settings. This was published before the cut-off date for inclusion of 2003. This was not retrieved as there is no explicit mention of transitions between in-patient hospital and community settings.

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						[5] Kakarlapudi et al (2003) The effect of diabetes on sensorineural hearing loss. Otology and Neurotology 24(3): 382-386;	This was not retrieved as there is no explicit mention of transitions between in-patient hospital and community settings.
						Mitchell et al (2009) Relationship of Type 2 diabetes to the prevalence, incidence and progression of age-related hearing loss. Diabetic Medicine 26(5): 483-8;	This was not retrieved as there is no explicit mention of transitions between in-patient hospital and community settings.
						Chasens et al (2010) Reducing a barrier to diabetes education: identifying hearing loss in patients with diabetes. Diabetes Education 36(6): 956-64	This was not retrieved as there is no explicit mention of transitions between in-patient hospital and community settings.
						[6] Formby et al (1987) Hearing loss among stroke patients. Ear and Hearing 8(6): 326-32;	This was published before the cut-off date for inclusion of 2003.
						Gopinath et al (2009) Association between age-related hearing loss and stroke in an older population. Stroke 40(4): 1496–1498	This was not retrieved as there is no explicit mention of transitions between in-patient hospital and community settings.
						[7] Chia et al (2006) Association between vision and hearing impairments and their combined effects on quality of life. Archives of Ophthalmology 124(10): 1465-70	This was not retrieved as there is no explicit mention of transitions between in-patient hospital and community settings.
						[8] Kiani R and Miller H (2010). Sensory impairment and intellectual disability Advances in psychiatric treatment. 16, 228–235;	This was not retrieved as there is no explicit mention of transitions between in-patient hospital and community settings.

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						Foundation for people with learning disabilities, 2015. Hearing Loss. [Online]. Available from: http://www.learningdisabilities.org.uk/help-information/learning-disability-a-z/h/hearing-loss/ [Accessed 31st July 2015]	This was not retrieved as there is no explicit mention of transitions between in-patient hospital and community settings.
						[9] Lin FR et al. (2011) 'Hearing loss and incident dementia'. Archives of Neurology 68 (2): 214-220;	This was not retrieved as there is no explicit mention of transitions between in-patient hospital and community settings.
						Gurgel et al (2014). Relationship of Hearing Loss and Dementia: A Prospective, Population-Based Study. Otology & Neurotology. 35 (5), 775-781;	This was not retrieved as there is no explicit mention of transitions between in-patient hospital and community settings.
						Albers et al (2015) At the interface of sensory and motor dysfunctions and Alzheimer's disease. Alzheimers and Dementia Journal, 11 (1), 70–98	This was not retrieved as there is no explicit mention of transitions between in-patient hospital and community settings.
						[10] Burkhalter CL et al. (2009) Examining the effectiveness of traditional audiological assessments for nursing home residents with dementia-related behaviors. Journal of the American Academy of Audiology 20 (9): 529-38;	This was not retrieved as there is no explicit mention of transitions between in-patient hospital and community settings.
						Boxtel van MPJ et al. (2000) 'Mild hearing impairment can reduce verbal memory performance in a healthy adult population'.	This was published before the cut-off date for inclusion of 2003.

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						Journal of Clinical and Experimental Neuropsychology 22 (1): 147-154.	
						[11] Davis et al (2007) Acceptability, benefit and costs of early screening for hearing disability: A study of potential screening tests and models. Health Technology Assessment 11: 1–294	This was not retrieved as there is no explicit mention of transitions between in-patient hospital and community settings.
						[12] Mulrow et al (1990) Quality-of-life changes and hearing impairment, a randomized trial. Annals of Internal Medicine 113(3): 188-94;	This was published before the cut-off date for inclusion of 2003.
						[13] Mulrow et al (1990) Quality-of-life changes and hearing impairment. A randomized trial. Annals of Internal Medicine. 113(3): 188-94;	This was published before the cut-off date for inclusion of 2003.
						National Council on the Aging. (2000) The consequences of untreated hearing loss in older persons. Head and Neck Nursing 18(1): 12-6;	This was published before the cut-off date for inclusion of 2003.
						Acar et al (2011) Effects of hearing aids on cognitive functions and depressive signs in elderly people, Archives of Gerontology and Geriatrics, 52(3): 250-2;	This was not retrieved as there is no explicit mention of transitions between in-patient hospital and community settings.
						Mulrow et al (1992) Sustained benefits of hearing aids. Journal of Speech & Hearing Research 35(6): 1402-5;	This was published before the cut-off date for inclusion of 2003.
						Goorabi et al (2008) Hearing aid effect on elderly depression in nursing home patients. Asia Pacific Journal of Speech, Language and Hearing 11(2): 119-123;	This was not retrieved as there is no explicit mention of transitions between in-patient hospital and community settings.

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						Cacciatore et al (1999) Quality of life determinants and hearing function in an elderly population: Osservatorio Geriatrico Campano Study Group. Gerontology 45: 323-323	This was published before the cut-off date for inclusion of 2003.
						[14] Dawes et al (2015) Hearing Loss and Cognition: The Role of Hearing Aids, Social Isolation and Depression. PLoS ONE 10(3): e0119616;	This was not retrieved as there is no explicit mention of transitions between in-patient hospital and community settings.
						Gurgel et al (2014) Relationship of hearing loss and dementia: A prospective, population-based study. Otology and Neurotology 35(5): 775-81;	This was not retrieved as there is no explicit mention of transitions between in-patient hospital and community settings.
						Lin et al (2011) Hearing loss and incident dementia. Archives of Neurology 68(2): 214-220;	This is an opinion piece and was not retrieved because it does not constitute empirical evidence.
						Lin et al (2013) Hearing loss and cognitive decline in older adults. Internal Medicine 173(4): 293-299;	This is an opinion piece and was not retrieved because it does not constitute empirical evidence.
						Uhlmann et al (1989) Relationship of hearing impairment to dementia and cognitive dysfunction in older adults. Journal of the American Medical Association 261: 1916-1919;	This was published before the cut-off date for inclusion of 2003.
						Pronk et al (2011). 'Prospective effects of hearing status on loneliness and depression in older persons: identification of subgroups'. International Journal of Audiology, 50 (12), 887-96;	This was not retrieved as there is no explicit mention of transitions between in-patient hospital and community settings.

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						Deal et al (2015). Hearing impairment and cognitive decline: A pilot study conducted within the atherosclerosis risk in communities neurocognitive study. American Journal of Epidemiology, 181 (9), 680-690 [15] NHS England. (2015). Accessible Information Standard. Availabe at: http://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/ [16] NICE (2013) Mental wellbeing of older people in care homes. QS50 [18] Echalier, M (2012). A world of silence. Available at: www.actiononhearingloss.org.uk/aworldofsilence [19] Ringham,, L. (2013). Access all areas. Available at: www.actiononhearingloss.org.uk/accessallareas	This was not retrieved as there is no explicit mention of transitions between in-patient hospital and community settings. Thank you for highlighting this. We have now made reference to the Accessible Information Standard in the overarching principles of this guideline. Thank you for this suggestion. The NICE transitions pathway will link this guideline to this and other relevant NICE guidelines and quality standards. This is an opinion piece and was not retrieved because it does not constitute empirical evidence. This is an opinion piece and was not retrieved because it does not constitute empirical evidence.
	SH	City of York Council Adult Social	Short	General	General	**Medication –** this may need some specific recommendations about management of and communication about medication before, during and after hospital admissions.	Thank you for your comment. The Guideline Committee considered that management of and communication about medication are aspects that have been covered in the guideline, for example in recommendations 1.1.4 and 1.1.5 which address the issues specifically and which also link to the

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		Services					NICE guideline on medicines optimisation.
	SH	Guild of Healthcare Pharmacists	Short	General	General	We wish to provide the following comments in relation to Question No. 2 'How can technology be better used to assist communication between hospital and community or care home settings as described in this guideline': We are aware that there are three aspects that would support effective technology if pharmacists and other healthcare professionals who need to, could access the systems at the necessary time: • Summary Care Record (SCR) – this is now rolling out across England. Pharmacists and others have read only access to Medicines information – this links to GP records, is live and as up to date as the GP record. However patients can opt out, and consent is required to access the record. • Special Patient Notes used by GPs and links to, and used by 111 and LAS, to highlight patients with particular care needs e.g. end of life / DNR, which appear to work well • Co-ordinate My Care – this is being developed from special patient notes to bring this across the system and if this works well it could develop into an updated version of SCR If pharmacists could access and upload to these systems, or to a single system, then anyone	Thank you for your suggestions. The Guideline Committee agrees that effective communication, supported by technology, is a key challenge but important to get right if this guideline is to be implemented. We will be encouraging organisations with relevant practice examples to submit them for the NICE database for shared learning and wider dissemination.

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						could have access once consent is approved. This would be very helpful in improving communications. However, it would not provide the prompt of a fax or telephone call with a discharge letter for a patient discharged from hospital with e.g. a Medicine Compliance Aid. Clearly there is a need for a better, integrated and automatic IT system, and although this does not remove the need for one-to-one communication it should make communications easier, quicker and more effective.	
	SH	Age UK	Short	General	General	On challenges to implementation, NICE should consider also looking at: - Medicines optimisation, particularly rationalising new and existing prescriptions once people have left hospital (and where the GP may disagree with any changes) and taking the opportunity to stop medicines that are no longer necessary. - Having sufficient training and understanding amongst non-palliative care staff in end of life care discussions. - Timely access to assessment and resolution of NHS continuing health care. - Assessment for mental health needs and treatment. - Choice of care home.	Thank you for your comment. We will consider these challenges in our implementation work.
	SH	Alzheimer's Society	Short	General	General	We would like to hear your views on these questions: 1. The Care Act 2014 sets out new	Thank you for your response to this consultation question. We will be encouraging organisations to submit examples or practice that are relevant to this guideline to the NICE database for shared learning and wider dissemination.

Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its officers or advisory committees

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						housing duties for local authorities to promote integrated health and care. How can local authorities and housing providers better help to assist the type of transition this guideline describes? One of the strongest messages from people with dementia is that people want a single, local, named contact to advise them about dementia and where they can get help. Alzheimer's Society dementia advisers are available in many local areas as named contacts for people with dementia and their carers from diagnosis to provide information and advice. At Salisbury District Hospital, Dementia Advisers are working with consultants and ward teams, who can identify patients with dementia, so that the right support is offered when they are discharged home. 2. How can technology be better used to assist communication	Thank you for providing these research examples.

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						between hospital and community or care home settings as described in this guideline. 3. What are your views on the draft research questions (section 3 of the short version)? Do you know of any research currently in progress that overlaps with these research questions? Title: What happens to people with dementia identified in general hospital? Institution: University of Warwick URL: http://www2.warwick.ac.uk/fac/med/research/mhwellbeing/projects/what_happens/ Description: The study identified people with dementia and followed them and their carers for one year, wherever they were discharged to. Key assessments were of quality of life, mood, carer stress and costs of care. We obtained this information by direct face-to-face interviews with people with dementia and their family carers. The study team brought together people with a wide range of clinical, academic and personal expertise, from universities, social and	

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						medical care, and personal experience of dementia care. Includes health economics case studies that show the costs of people with dementia leaving hospital (http://www2.warwick.ac.uk/fac/med/research/mhwellbeing/projects/dagh/). Title: Alzheimer's Society Bradford Doctoral Training Centre: transitions in care theme Institution: University of Bradford URL: http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=2882 Description: The Centre will be launched in October. Some students are studying the transition between care homes and hospitals, including designing a system for reducing medication errors and developing best practices for nurses. There are also studies into the transition between home and hospital. One PhD student will be aiming to design a support package to enhance communication between people with dementia, family carers and health professionals during hospital admission. Another is looking at the role of the	

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						community pharmacy in providing support for people with dementia after discharge from hospital. Title: Services after Hospital: Action to develop REcommenDations (SHARED) Institution: University of Warwick URL: http://www2.warwick.ac.uk/fac/med/research/hscience/rcn/research/themed/nihrproject/ Description: Study that focuses on the experiences of carers and people with dementia from hospital discharge to 12 weeks post discharge particularly what works well, what can be improved, and involvement in decision making around service provision. The project finishes at the end of 2015 and is in the data analysis stage. 4. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. 5. What would help users overcome any challenges? (For example, existing practical resources or	

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						national initiatives, or examples of good practice.)	
	SH	Foundations	Short	General	General	**Home from Hospital Schemes-Examples of Good Practice** **1.Manchester Care and Repair** **Commissioners**: Partnership between 3 CCGs, Manchester City Council and Pennine Acute Hospital NHS Trust **Prevention**: Focus on contacting people with moderate needs NOT eligible for statutory support **Integration**- Working in partnership with Re-ablement and Intermediary Care teams as well as Integrated Discharge teams. **Information/Advice**- Signposts vulnerable cases to wider services to ensure independence **The Service**- The service targets by phone, people with moderate needs being discharged from hospital. From September 13 to 14, 20% of the 8000 people contacted accepted building related support from the service. Building related support including small repairs/adaptations provided by the agency Handyperson Service. 50% of those successfully contacted benefitted from the advice and information provided by the agency caseworker. **Outcomes**: CCG noted a significant reduction in the number of people 60+ being readmitted to hospital within 30 days in North and Central Manchester. People report back saying they feel supported, less at physical risk with an increase in well-being. Having a safe warm habitable property significantly reduces	Thank you for your comment. We will consider your good practice examples in our implementation work.

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						the risk of falling, ill health and consequent readmission. **2 Swan Housing Association Homecare Support Service** This service coordinated by the Home Improvement Agency integrates 3 preventative services within a single gateway. The principle being that a patient being discharged or at risk of being admitted will receive a personalised service provided by a care worker and handyperson within 4 hours of being referred by a doctor, nurse or social worker. They will then receive a short term package of support for up to 6 days including a home safety check, adaptations and personal care. Service aims are to ensure people remain and receive care at home, avoid unnecessary hospital and residential care admissions and are supported prior to a crisis, to regain their independence. The scheme operating in North East Essex is able to see 87% of people referred within 4 hours who are provided with a housing and care package. Significantly 96% of people referred elect to use the scheme rather than being hospitalised. Also following research findings clients are able to recover better at home rather than in a hospital environment. A recent Social Return on investment analysis has shown that for every £1 spent on the scheme, £8 was saved on additional hospital bed spaces and wider community budgets.	
	SH	Royal Pharmaceutical	Short	General	General	Problems with medicines are a common reason for admissions and re-admissions into hospital. There is a substantial body of evidence that	Thank you for your response. Recommendation 1.1.4 now cross references NICE's guideline on medicines optimisation. In particular, it references sections 1.2 and 1.3 on medicines-

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		Society				shows when patients move between care providers the risk of miscommunication and unintended changes to medicines remain a significant problem. 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. Despite this, there is little focus on medicines within these guidelines and yet they are an important part of every section of this guideline as demonstrated below.	related communication and medicines reconciliation during transitions.
	SH	Royal Pharmaceutical Society	Short	General	General	We believe that there should be a research question which explores the benefits of having a follow up medicines review in primary care after discharge.	Thank you for your suggestion. We acknowledge that this is an area that would benefit from further research. Unfortunately the number of research recommendations that can be made in the guideline are limited. The Guideline Committee can only make research recommendations in response to gaps in evidence that have been identified through the evidence review. Research recommendations were prioritised by the committee in response to gaps identified in the evidence.
	SH	Royal College of Nursing	short	General	General	The Royal College of Nursing welcomes the opportunity to comment on this draft guideline on the transition between inpatient hospital settings and community or care home settings for adults with social care needs. The RCN also invited members who care for people in the community to comment on the draft guidelines. The comments below include the views of our members.	Thank you.
	SH	Royal	short	Gene	Gene	The language does not promote patient and	Thank you for your comment. We agree with the point you

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		College of Nursing		ral	ral	carer involvement but produces a list of interventions that must be done, rather than eliciting the involvement and the resources of the individual, this is particularly notable in care planning in 1.2.1 where the patient and family should be asked first about their care plan at times of transition.	make about the wording in recommendation 1.2.1. In the final guideline we have therefore changed the recommendation to emphasize that care plans should be made *with* and not for a person.
	SH	Royal College of Nursing	short	General	General	There is little reference to involvement of the voluntary sector, particularly in providing support and help with housing. This would be an area of great impact, the work of Age UK and the Red Cross could be looked at to inform the guideline.	Thank you for your comment. The Guideline Committee had not intended to overlook the contribution of the voluntary sector in supporting transitions. Therefore in the final guideline, reference to the voluntary sector has been made more explicit, for example by including voluntary sector practitioners in the hospital- and community-based multi-disciplinary teams and by recommending that the discharge coordinator should arrange follow up care for people before discharge, which will include support from the voluntary sector. A definition of voluntary sector has also been added to the glossary so the audience is clear about what we are referring to.
	SH	Royal College of Nursing	short	General	General	Assessment for continuing health care is conspicuously absent in this draft guideline.	Thank you for your comment. In light of yours and other stakeholder comments, the Guideline Committee discussed this issue and were in agreement about the need to include it. The Guideline Committee also agreed that a reference should be made to assessments for funding ongoing social care. They reached a consensus that 'assessments for health and social care eligibility' should be added to the list of factors that might prevent a safe, timely discharge from hospital (1.5.13). They also added 'how to arrange assessments for eligibility for health and social care' to the list of areas related to hospital discharge in which staff are trained (1.7.1).
	SH	Royal College of Nursing	short	General	General	At each transition phase, including within the hospital environment, assessment should be made with the use of appropriate technology.	Thank you for your comment. The Guideline Committee was unable to make recommendations about the use of technology during assessments because none of the research provided evidence in this area.
	SH	Royal College of	short	General	General	There is no reference to the use of emerging communication tools that will help assist in transition- email communications, Summary	Thank you for your comment. Recommendation 1.4.1 does state that multi-disciplinary assessments, prescribed and non-prescribed medicines and individual preferences should be

Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its officers or advisory committees

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		Nursing				Care Record, Shared electronic records.	recorded in an electronic data system. The recommendation also states that the system should be accessible to both the hospital and community based multi-disciplinary teams. The Guideline Committee developed this recommendation based on evidence describing the negative consequences of practitioners failing to share information and suggested means of addressing this though electronic systems. Testimony from the expert witness supported this.
	SH	Royal College of Nursing	Short	General	General	The term carers was used several times in the guideline. Our members consider that the guideline needs to also clearly state that carers also includes care home staff- needs to cover formal and informal caregiving	Thank you for highlighting this.Where we refer to carers in the recommendations, we mean '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. For clarity, the term 'carer' is defined in the 'terms used in this guideline' section. Where a recommendation refers to a carer this is because the Guideline Committee felt the research review provided them with evidence of sufficient strength and quality to do make the recommendation. The evidence was specific to carers and the Guideline Committee felt unable to extrapolate to other populations such as formal care workers or practitioners.
	SH	Royal College of Nursing	Short	General	General	Our members suggest that the guideline should give consideration to the use of eHealth technologies- Sypke/ teleconferencing) to enable care home staff to be present at multidisciplinary team (MDT) meetings or panel discussions when discharge planning. Too often care homes are only told about discharge as the transport arrives to take people home.	Thank you for your comment. We recognise the difficulty reported by your members but unfortunately the research review did not provide any evidence about the use of Skype or e-health technologies. The Guideline Committee was therefore unable to cite this technology in the recommendations.
	SH	Royal College of Nursing	Short	General	General	Our members consider that the challenge within this draft document is the need to break down the barriers with good robust communication between hospital, all relevant community teams including care home personnel, as well as the cultural shift needed to understand the different environments within community and hospital.	Thank you for your comment. We agree about the importance of improving communication within and between hospital and community based teams and people and their families in order to improve transitions. Many of the recommendations focus on this issue, for example recommendation 1.3.8 which states that the hospital based multi-disciplinary team should work with the community based multi-disciplinary team to ensure coordinated

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							transitions. Also, 1.1.4 which states that the person, the carers and all health and social care practitioners involved in someone's move between hospital and home should be in regular contact with each other to ensure the transition is coordinated and all arrangements are in place. The point you highlight will also be considered in our implementation work supporting this guideline.
	SH	Royal College of Nursing	Short	General	General	Our members consider that a joined up electronic healthcare system is really the most effective way forward for improving care in and out of hospital.	Thank you for your comment. Having reviewed the evidence, the Guideline Committee agree with you about the importance of recording and sharing information on electronic data systems. They developed recommendation 1.4.1, which emphasizes the important of using electronic systems which are accessible to both the hospital and community based multi-disciplinary systems.
	SH	Derbyshire County Council	Short	3	general	bullet point – should we add 'waiting for continuing healthcare decision/implementation'	Thank you for your comment. In light of yours and other stakeholder comments, the Guideline Committee discussed this issue and were in agreement about the need to include it. The Guideline Committee also felt that reference should be made to assessments for funding ongoing social care. They reached a consensus that 'assessments for health and social care eligibility' should be added to the list of factors that might prevent a safe, timely discharge from hospital (1.5.13). They also added 'how to arrange assessments for eligibility for health and social care' to the list of areas related to hospital discharge in which staff are trained (1.7.1).
	SH	Derbyshire County Council	Short	3	6	Should read hospital discharges not admissions	Thank you for your comment. We have not changed the text to which you refer because the intention was to cite hospital admissions rather than discharge. The point being made is that if hospital admissions are not coordinated this will have a knock on effect, potentially causing delayed transfers of care.
	SH	Derbyshire County Council	Short	3	11	can we add 'or reinstated' after finalised	Thank you for your comment. We recognise the point you are making but in the final guideline, the list of causes of discharge problems has actually been changed. It is now the list used in the Monthly Situation Reports, collated by the Health and Social Care Information Centre, for monitoring delayed transfers of care. The list refers to delays because people are

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							awaiting a car package in their own home and arguably this does not specify whether this is a new or reinstated package.
	SH	Macmillan Cancer Support	short	4	8	In the context of a complex and rapidly changing landscape, and changing provision of care / services, it is important to consider how the people involved in the discharge and care transition process are kept updated. Specifically, how a local directory of services and access criteria are to be maintained and updated.	Thank you for your comment. The Guideline Committee agrees that it is important for all practitioners to be knowledgeable about the range of available services for supporting transitions. This is reflected in recommendation 1.6.3. The point you highlight will also be considered in our implementation work supporting this guideline.
	SH	NHS Providers	short	4	11	We welcome the focus in the guideline on "what works" and how organisations can fulfil their duties as per the Care Act 2014.	Thank you for your support.
	SH	United Kingdom Homecare Association	Short	5	2-3	It may prove helpful to cross reference specific issues to the Care Act rather than an open message that 'the guidelines should be read in conjunction with' to avoid misinterpretation or omission	Thank you for your suggestion. In order to keep the recommendations as clear as possible, we have not made this change. It is the case that the whole of the guideline must be considered in conjunction with the Care Act so it is appropriate to communicate this broad message.
	SH	Macmillan Cancer Support	short	5	5	Macmillan has been supporting the implementation of Holistic Needs Assessment as part of the Recovery Package to support people after cancer treatment. This involves the person completing a questionnaire either paper or electronic to identify their current needs and concerns; this can be undertaken before they leave hospital, before a clinic appointment, within general practice or at home. The professional or advocate then develops a care and support plan in partnership with the person to address the needs. This has demonstrated that people raise concerns more readily if asked to complete the questionnaire; the electronic tool is easy to use and provides aggregate data locally and nationally on needs and the person feels their needs are better met. The older person's holistic needs assessment is currently	Thank you for your comment. The Holistic Needs Assessment initiative sounds very much in keeping with the recommendations of our guideline. Person-centred care – recognising each person receiving care as an individual who should be treated with dignity and respect - is an overarching principle of the guideline (recommendation 1.1.1). We also have recommendations on advance care plans and contingency planning which highlight that discussions might cover the use of an advocate to support with communicating needs and preferences (see recommendation 1.2.1 and 1.2.3).. We are only able to make recommendations based on evidence which meets our inclusion criteria but thank you for sharing details of your pilot scheme.

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						being piloted with a view to incorporate into the electronic tool.	
	SH	NHS Providers	short	5	5	We support the principles outlined in the description of "person-centred care"	Thank you for your comment and for your support of the 'person-centred care' principles which are a key aspect of the guideline.
	SH	Macmillan Cancer Support	short	5	15	Research commissioned by Macmillan identified that • Half of people who care for those with cancer (51%) say the word 'carer' does not describe them • Half of carers of people living with cancer (49%) do not get any support at all, and only 5% receive a formal assessment of their needs from their local Authority • 47% of cancer carers can identify at least one type of support they are missing out on that would help them in their caring role – most commonly, advice and training on how to provide care • Professionals do not routinely identify cancer carers and signpost them to support, and this support is not uniformly available or accessible throughout the UK • just under half (46%) of people currently caring for someone with cancer are in full-time work, representing around 500,000 people in the UK. Many will also have dependent children at home. It is therefore important that there is • **Increased collaboration to identify carers:** Healthcare providers must work with local authorities to formally identify, assess and support people who care for those with	Thank you for your comment. As described in the context and introduction this guideline was developed in line with the Care Act 2014. The new Act replaced the previous requirement for carers to be conducting a 'regular or substantial' caring role, or to request an assessment. The new legislation means that all carers have the right to receive (or refuse) an assessment regardless of their needs for support or their financial resources, or those of the adult they care for. There are sections of the guideline called 'Involving carers' (1.5.29 – 1.5.31) and 'Support and training for carers' 1.5.32 – 1.5.35). The guideline reiterates that families and carers can act as a useful source of information to health professionals, and that their willingness to provide support, circumstances and relationship to the person should all be considerations when writing a discharge plan. There are specific recommendations on training carers and the practical and emotional aspects of providing care.

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						cancer - **Increased support for carers to carry out their caring role** As well as support to meet their own needs, carers need advice, training and support to provide care safely and effectively. This particularly applies to any healthcare tasks or personal care they choose to provide to the person they care for.	
	SH	NHS Providers	short	5	15	Our members appreciate the recognition in the guidelines of the role of families and carers, and the need for them to be involved in decisions about care and support (if the service user agrees) and to be appropriately supported in their caring role.	Thank you for your support. The research questions sought the views and experiences of families and carers as well as asking how services should work with families and carers during hospital transitions. The recommendations are derived from the best available evidence on this topic.
	SH	Older People's Advocacy Alliance OPAAL UK	Short	8	General	OPAAL welcomes the focus on person centred support in the transition between hospital, community and care home settings. This section on communication and information sharing should be extended to set out the types of support, including independent advocacy that can support older people to make informed choices, have their voice heard and feel listened to.	Thank you for your comment. Access to advocacy for those at risk of less favourable treatment now appears in 1.1.2 within the 'person-centred care' section. Advocacy, and empowerment through discussion with advocates, feature in 1.2.3 "Before Admission to Hospital" and 1.3.5 which highlights that the person being admitted should be given the opportunity to discuss their care (whether through an advocate or otherwise).
	SH	Royal College of Surgeons	Short	8	4-26	Right to advocacy if required. If a patient has capacity issues and no family they require timely access to a trained advocate Awareness of staff of those with little social or family support Awareness of other vulnerable groups, not just the elderly, such as those with learning disabilities and mental health issues	Thank you for your comment. Access to advocacy has now been included in recommendation 1.1.2 about supporting people who are at risk of less favourable treatment or with less access to services. There is also a recommendation that references the Equalities Act 2010. Recommendation 1.3.6 states that the admitting team must identify whether there is a need for reasonable adjustments to be made to accommodate the person in hospital. This covers any communication aids which may be necessary or ensuring that there is sufficient space around the

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							bed for wheelchair users.
	SH	The Patients Association	short	8	1.1	The Patients Association agrees with the 'Overarching principles of care and support during transition', as it is patients centred.	Thank you very much for your support.
	SH	Royal College of Speech and Language Therapists	Short	8	1.1.2	The RCSLT welcomes the recognition by NICE that people with communication difficulties often receive less favourable treatment and are pleased this this will be a key focus area for NICE.	Thank you very much for your comment.
	SH	Royal College of Speech and Language Therapists	Short	8	1.1.3	Mental capacity is mentioned quite often in the guideline and alongside this we recommend adding how people and their families will be supported to make decisions. Speech and language therapists can develop and support strategies to enable an individual to access information appropriately, express their views and make decisions. This is important for the individual to exercise choice and to ensure that consent is sought. There is frequent reference about capacity. However, our members' report that in some acute settings capacity is not always assessed and medical teams sometimes make assumptions and decisions in the interests of the patient. We recommend an increased emphasis on supporting individual's communication so they are able to make decisions.	Thank you for your comment. Under the section 'Establishing a hospital-based multidisciplinary team' recommendation 1.3.7 now describes the composition of the team as including • therapists. Therapist has been pluralised so it now covers speech and language therapists as well as physio- and occupational therapists

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	SH	Royal College of Speech and Language Therapists	Short	8	1.2.2	We are unsure which health and social care practitioners will develop the care plan? To understand the often complex communication problems experienced by adults, input and support from a speech and language therapist is crucial.	Thank you for your comment. In keeping with the overarching principle of person-centred care it was not considered suitable to stipulate the exact health and social care practitioners that would be involved in developing a care plan. Ideally the professionals involved in a person's care would reflect their needs as an individual. Therapists - including speech and language therapists - has been added to the list of possible members of the hospital-based multidisciplinary team.
	SH	Stockton-on-Tees Borough Council	Short	8	1.1.4	In Stockton-on-Tees BC we are developing a Multi-Disciplinary Service in partnership with the NHS Hospital Foundation Trust to ensure everyone involved in someone's move between hospital and home maintains regular contact. This is currently achieved through close partnership working.	Thanks for your comment and for passing on information about your initiative.
	SH	Royal College of Speech and Language Therapists	Short	8	1.1.5	In addition to offering information in a language which the patient can understand, it is important that the individual is supported to ask and answer any questions allowing the person to address and shape decisions. Attempts must be made to ensure that the person actually understands the information.	Thank you for your comment. The Guideline Committee have been mindful of the importance of checking that the person has understood the information presented and that they are given the opportunity to ask questions. Recommendation 1.3.5 highlights that the admitting team should provide the person and family, carer, or advocate with an opportunity to discuss their care.
	SH	Royal College of Speech and Language Therapists	Short	8	1.1.5	All information needs to be presented in an appropriate format for the individual that they understand and must include non-verbal formats for example video and other digital formats that can support communication.	Thank you for your comment. The Guideline Committee felt that the issue of accessible and appropriate information was well covered in the guideline. Recommendation 1.1.6 under 'Overarching principles of care and support during transition' refers to formats that are easy for the person to understand, such as braille, Easy Read or translated material. This list is not exhaustive.
	SH	Royal	Short	8	1.1.5	All information should take account of the	Thank you for your comment. The Guideline Committee are

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		College of Speech and Language Therapists				person's mental capacity, any communication difficulty, and language preference.	confident that in referring to the Mental Capacity Act and espousing the use of communication formats that are easy for the person to understand the guideline takes these highlighted communication needs into account.
	SH	The Patients Association	short	8	1.1.5	Information should be offered in accessible formats and languages, particularly if consent is to be obtained. However, to save costs we should ensure that publications in other languages should be 'demand led'.	Thank you for your comment. It is beyond NICE's remit to make recommendations relating to the amount of translated material which is produced. However, as the recommendation about producing translated material (1.1.6) is person-led it implies that publications should only be produced on a 'demand led' basis.
	SH	Royal College of Nursing	short	8	1.1.5	We commend the use of Easy Read guidance about Hospital Admissions. This will require some sort of infrastructure for its delivery, as this likely only happens presently when a member of the Community Learning Disability team are already involved.	Thank you for your comment. Guideline Committee members were very keen to make it clear in this guideline that all information should be provided for people in formats that are easy for them to understand and that that they receive appropriate support to help them to communicate. This is in accordance with the new 'accessible information standard' which was approved in June 2015. Recommendation 1.1.6 now directly references the Accessible Information Standard. All organisations that provide NHS or adult social care must follow the accessible information standard by law. Advice from NHS England is that a range of advice, guidance and tools to support effective implementation of the standard will be published over the coming months. http://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/
	SH	Royal Pharmaceutical Society	Short	8	4	Each individual should be involved in the decisions about their medicines, whether it is starting, changing or stopping a medicine.	Thank you for your comment. Recommendation 1.1.1 captures the need to treat each individual receiving care as an equal partner who can make choices about their own care. Recommendation 1.1.4 cross references NICE's guideline on medicines optimisation. In particular, it references sections on medicines-related communication and medicines reconciliation during transitions. Medicines reconciliation has also been added to the glossary to describe the process of identifying the

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							changes in medicines to look for any discrepancies.
	SH	Airedale NHS Foundation Trust	Short	8-9	15-2	Agree with the principle of information sharing, however in practice is very difficult when IT systems are not shared between organisations and the governance arrangements within Organisations do not permit the sharing.	Thank you for your comment. The Guideline Committee reasoned that this was an aspirational recommendation. As electronic data systems facilitate information sharing in some UK practices it was felt that it should be included. The guidance is not statutory and, furthermore, it is qualified by the phrase 'subject to information governance'
	SH	Age UK	Short	8	14	Dementia and cognitive health should be explicitly included with regards to communication. The people for whom this guidance is most relevant are likely to have a high relative prevalence of dementia and cognitive decline. The National Audit of Dementia (2014) has said that "understanding a person's need for social interaction, communicating clearly, and working at their pace, could have helped to prevent confusion or distress and aided in carrying out essential care". Yet only 59 per cent of hospitals reported including dementia awareness in their staff inductions. The ability for all staff to engage and communicate with people with dementia is crucial to the transition through hospital and all settings must be expected to have robust practices in place.	Thank you for your comment. Recommendation 1.5.10 under 'Discharge planning: key principles' refers to ensuring continuity of care for people who are being transferred from hospital - particularly older people who may be confused or have dementia. While the Guideline Committee recognised the importance of including dementia awareness in staff inductions they can only make training recommendations based on evidence which reaches the inclusion criteria.
	SH	SeeAbility	Short	8	20	The use of the term is "should" which appears more optional than a "must". We would like to stress that learning disabilities and sight loss must have discharge documentation presented to them in an accessible manner as required by NHS England Accessible information standards, which should be referenced http://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/	Thank you for your comment and for drawing attention to this important document. Recommendation 1.1.6 now links directly to the Accessible Information Standard. The recommendation is in the 'overarching principles' section and is strongly worded.
	SH	Macmilla	short	8	24	Macmillan Direct Services offer support for	Thank you for your comment and for providing information

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		n Cancer Support				people affected by cancer and for professionals. The Macmillan Support Line offers support through 4 main teams: 1. Cancer information support team, providing emotional support, local information and signposting. In 2014, 147000 enquiries were taken by the Cancer information support team. 2. Cancer information nurse specialists, provide clinical information and support, emotional support and up to date research. Our 32 nurses provided information via telephone and email to over 35,000 customers in 2014. They are also providing information via social media. 3. Welfare rights team, providing assessment of finances and access to grants, benefits, and energy advice. Our welfare rights team gained £52 million for our customers in 2014. 4. Financial guidance team assess and access insurance, pensions and mortgage help for our customers. They also deal with private medical insurance claims and have accessed £2.9 million in financial gains in 2014. Direct Services also deliver Macmillan Grants to people affected by cancer. Macmillan grants can be accessed both through the support line and via professionals. In 2014 we gave £10.2 million in grants for a variety of things from fuel to travel costs. Interestingly 40% of grants are accessed by the same 4% of professionals. This indicates a need to find out why a large portion of professionals do not access grants for	about the range of support and services you offer.

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						their patients. Macmillan also has the largest online community for people affected by caner in Europe with over 856,000 users in 2014. Nearly a quarter of these users are in the age group 45-54. Cancer information and publications are produced by the Cancer information development team. What is clear is that information provision must take into account health literacy. Our publications are produced at reading age 12 to ensure a wider understanding by our audiences. Publications are also available in different formats for example audio, foreign languages and video. 74% of web traffic on Macmillan website was for cancer information. In 2014 over 1.8 million booklets were ordered, "Help with the cost of cancer" accounts for 7800 of those sent out. Furthermore, we deliver the mobile information service. Our mobile teams attend events, set up in local areas around the country providing information and support in often hard to reach communities. 2014 saw 78,500 people access our mobile information services.	
	SH	Royal Pharmaceutical Society	Short	8	24	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	Thank you for your comment and for sharing a link to your relevant guidance. Recommendation 1.1.4 now cross references NICE's guideline on medicines optimisation. In particular, it references sections 1.2 and 1.3 on medicines-related communication and medicines reconciliation during transitions. Unfortunately we are unable to cross refer to any guidance or recommendation apart from those developed by NICE.

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	SH	United Kingdom Homecare Association	Short	9	General	This section would be more effective if entitled 'prevention of hospital admission'	Thank you for your comment. Hospital admission avoidance that does not specifically involve a transition between settings was beyond the remit of the scope. Care and planning to prevent admissions to hospitals is a much wider topic and was deemed to be out of the scope of this topic. See section 4.3.2 of the scope 'Areas that will not be covered'.
	SH	Royal College of Surgeons	Short	9	2-7	Planned care admissions- social care needs need to be explicitly included in pre-planning of elective care In a survey of surgeons by the College in 2014, one of the recommendations was that discharge planning needs to be taken into account earlier, even at pre-assessment	Thank you for your comment. The Guideline Committee considered that section 1.2 "Before admission to hospital" adequately covered the inclusion of social care needs in pre-planning. 1.5.13 also recommends that planning for a safe, timely transfer of care should start from admission *or earlier if possible.*
	SH	United Kingdom Homecare Association	Short	9	16-19	The prescription of a care package by (in this example) community care practitioners would commit secondary or tertiary providers to a programme that might not subsequently be clinically appropriate, operationally deliverable or in keeping with the prevalent situation and it is inadvisable to expect community practitioners to be in a position to determine what should, could or ought to happen in an acute setting, particularly concerning the issues raised in lines 16, 18, 19	Thank you for your comment. The Guideline Committee agreed that plans determined in hospital cannot be imposed on a care home or other provider(s). However, they reasoned that the recommendation did not need to be changed as there is no prescription of a 'care package' within the recommendation.
	SH	Derbyshire County Council	Short	9	5-7	Great that we are advocating a care plan for those at risk of being admitted. Sharing this plan with the hospital team may be challenging as relies on joined up IT systems or other method. Suggestions as to how to do this would be great.	Thank you for your comment. The guideline recommends recording information on an electronic data system (1.4.1); while this may not always be possible in current UK practice the recommendation is intentionally aspirational. The Guideine Committee did not consider that the evidence informing 1.4.1 provided grounds to make reference to specific methods or systems for information sharing.
	SH	Derbyshire County Council	Short	9	8-10	not sure this would be necessary for everyone with social care needs??	Thank you for your comment. This recommendation has now been changed to "If a community multidisciplinary team is involved in a person's care.." so as not to infer this would be a

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							relevant course of action for everyone with social care needs.
	SH	Stroke Association	Short	9	4-5	While we agree that support to manage health conditions will reduce unnecessary hospital admissions, we are concerned that patients, families and care staff may be encouraged to 'manage' the symptoms of stroke rather than seeking medical attention. A clear distinction must be drawn between health conditions which can be managed safely and which symptoms need urgent medical attention.	Thank you for your comment. This recommendation has been amended to clarify that contingency planning is intended to help people in all aspects of their life, not just to manage their health condition. As such this recommendation has now been amended to "Include contingency planning. If they are admitted to hospital, refer to this plan." The Guideline Committee did not feel that there was any risk that this recommendation could be misinterpreted to mean that people were expected to manage symptoms of stroke at home.
	SH	SeeAbility	Short	9	1	Alongside sharing of information prior to admission, for some people, transition visits can aid the process and co-operation with treatment. It would be helpful to highlight this in this section.	Thank you for your comment.. As the review did not locate any evidence on 'transition visits' it is not possible to make a new recommendation at this point.
	SH	Age UK	Short	9	1	This section on *Before admission to hospital* does not acknowledge multi-morbidity as a significant risk factor in planning for care and avoiding admissions. Older people, particularly those with social care needs, are highly likely to live with multiple conditions, with around 60% of people over 75 living with two or more major long-term conditions. In this section, we recommend referring to "health conditions". Further related point below (point 4).	Thank you for your comment. The Guideline Committee agreed that it was likely that the person may have more than one health condition. However, on the premise that contingency planning should deal with a person's holistic needs and well-being (rather than just their health condition(s)) the wording has been amended to "This should include contingency planning."
	SH	The Patients Association	short	9	1.2	Before admission to hospital, health and social care practitioners should develop a care plan that must be recorded onto a standardised template with the patient as well as with the input of their carers or family members. This should include considerations on cultural issues of importance, as these may be missed even if the conversation covers religion and spirituality, as per 1.2.3.	Thank you for your comment. Recommendation 1.2.3 now includes 'religion, *culture* and spirituality' as a bullet point of what discussions might cover.

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	SH	Stockton-on-Tees Borough Council	Short	9	1.2.1	We would want to be assured the "care plan" is held by the client / relatives and that a record is kept of its whereabouts so that in an emergency it can be easily located and taken with the person to hospital.	Thank you for your comment. The Guideline Committee felt that this recommendation should not be so specific. Care plans are used and managed in different ways so it would not always be appropriate to have a record of its whereabouts available to all people at all times.
	SH	Royal College of Speech and Language Therapists	Short	9	1.2.1 1.2.3	All care plans should include a detailed description of the individual's communication difficulties alongside what support they need to communicate and convey their wishes and decisions. This should clearly identify how health and social care practitioners need to adapt their own communication to support the individual. When communication needs are complex speech and language therapists should support the process. These descriptions are particularly important at times of transition into and out of hospital to help individuals understand changes in their life.	Thank you for your comment. The care plan should outline *all* needs (including communication needs). The Think Local Act Personal definition of 'care plan' which we signpost to describes a care plan as a written plan which sets out care and support needs.
	SH	Royal College of Nursing	short	9	1.2.1	Patients and carers should be involved in the development of care plans and asked directly to communicate plans between transitions. Reference should be made to any advance directives and state if anyone holds lasting power of attorney. People and their caregivers are the owners of the care plans	Thank you for your comment. The wording of this recommendation has now been changed from 'develop a care plan for' to 'develop a care plan *with*' in order to emphasise their active involvement. The overarching principles highlight that people and their carers should be able to make choices about their own care.
	SH	Royal College of Nursing	short	9	1.2.1	Care Plan could refer to many different tools. Local groups will want to take a position on the relevant tools. This ought to consider electronic options to reduce duplication.	Thank you for your comment. By referring to the Think Local Act Personal definition of care plan we are not stipulating whether the care plan exists in an electronic format or not. Since the care plan should be individualised to each person's needs it is not appropriate to highlight any one kind of tool over another.
	SH	Stockton-on-Tees Borough	Short	9	1.2.2	The development of a Multi-disciplinary service in Stockton-on-Tees will work across both hospital and community teams to ensure	Thank you for your comment and for sharing information about your current practice. Information governance is a recurring issue. The Guideline Committee developed this

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		Council				improved communication. At present the issues associated with the sharing of information between health and social care organisations hasn't been resolved to the satisfaction of information governance.	recommendation based on evidence describing the negative consequences of practitioners failing to share information and suggested means of addressing this though electronic systems. Testimony from the expert witness supported this
	SH	Royal College of Nursing	short	9	1.2.2	The patient and carer should be able to identify who this person is.	Thank you for your comment. The Guideline Committee agreed that the person and their carer should be able to identify the assigned member of the community disciplinary team. The recommendation has now been changed to reflect this: "If a community multidisciplinary team is involved in a person's care that team should give the hospital multidisciplinary team a contact name. Also give the named contact to the patient and their family or carer."
	SH	Royal College of Nursing	short	9	1.2.2	Members of the relevant community multidisciplinary team may well not be aware of planned admissions.	Thank you for your comment. This recommendation is based on the best available evidence and is intended to be aspirational.
	SH	Royal College of Speech and Language Therapists	Short	9	1.2.3	It is crucial that practitioners take steps to ensure that the person understands the information that they are given.	Thank you for your comment. The importance of supplying information in an accessible and appropriate format is highlighted in the overarching principles (recommendation 1.1.6). The guideline also recommends that the person (and family/ carer/ advocate where appropriate) should be given the opportunity to discuss their care throughout the transitions process.
	SH	Royal College of Speech and Language Therapists	Short	9	1.2.3 1.2.4	People with advanced communication problems, or cognitive problems, may struggle to convey their choices at end of life. Support from family, carers and a speech and language therapist will be vital to ensure that people can make their own choices. Speech and language therapist assess an individual's capacity to communicate and understand information and to advise on the most effective means of presenting information and choices to the individual, maximising their opportunity to exert free choice.	Thank you for your comment. Therapists (including speech and language therapists) are now listed as roles that could comprise a hospital-based multi-disciplinary team. Recommendation 1.2.3 suggests that end-of-life care might be covered during advance care plan discussions; however recommendation 1.2.4 has now been deleted as the Guideline Committee considered that end of life care preferences were adequately covered in recommendations 1.2.3 and in the 'Discharge planning for end-of-life-care needs' section (1.5.22 – 1.5.24)

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						This is essential to allow the individual to exercise choice in treatment, choice at end of life and dignity in life and death.	
	SH	Royal College of Nursing	short	9	1.2.3	Sexuality and technology needs must also be identified.	Thank you for your comment. Recommendation 1.2.3 has been amended to cover culture (as well as religion and spirituality), and 'use of equipment and medicines; has been added to 'daily routines'.
	SH	Stockton-on-Tees Borough Council	Short	9	1.2.4	The reference to finding out and recording the person's wishes "during end of life care" should be amended to "before end of life care". It is sensible for people to consider their personal wishes regarding end of life scenarios well before they get to the stage of being at the end of life.	Thank you for your comment. The recommendation that you are referring to has now been deleted because the GC considered it was adequately by adding 'end of life care' to recommendation 1.2.3. 'End of life care' appears as one of the points in 1.2.3 to cover (if necessary) during advance care plan discussions. Placing the recommendation here allows people to consider their personal wishes regarding end of life care before they get to that stage.
	SH	Royal College of Nursing	short	9	1.2 – 1.2.4	General comment – 'Before Hospital Admission tends to concentrate on elective admissions, Our members have indicated anecdotally, people with learning disabilities are more likely to be admitted via A&E. As such wondered if there should be some guidance around preparing for this type of admission, or recommendation as to why these admissions appear to disproportionately high in some areas?	Thank you for your comment. The Guideline Committee did not feel it was appropriate to differentiate between elective or non-elective admissions because best practice would apply across both of these types of admission types.
	SH	NHS Providers	Short	9	3	The term "at risk" may be too general, as many adults with identified social care needs could be considered broadly "at risk" of admission. Different wording, such as "at significant risk", may be more in line with existing risk stratification protocols used by NHS and care providers. See also P17 l18, p19 l16.	Thank you for your comment. The Guideline Committee did not feel it was appropriate to add the qualifier 'significant' to 'at risk'. As 'significant' may mean different things to different people it was deemed to be an arbitrary measure and unlikely to enhance the meaning of this recommendation.
	SH	Macmilla	short	9	8	As previously highlighted, Macmillan is	Thank you for your comment we acknowledge the continuously

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		n Cancer Support				concerned about the lack of capacity within community services to coordinate support for people with a long term condition that may include cancer. We would consider this to be a major challenge for implementation.	challenging context within which this guideline has been developed and the pressures within the system within which it will be implemented. As part of our implementation support we aim to highlight other resources that can help, as well as encouraging submission of practice examples for shared learning- e.g. where local systems have successfully addressed capacity issues. Through NICE pathways, stakeholders will be able to make the link to other relevant NICE guidelines.
	SH	NHS Providers	Short	9	8	According to the standard procedures of many NHS providers, a coordinator would normally only be routinely assigned for people with more than one long term condition. Those with one long term condition would usually follow the care pathway for their specific condition.	Thank you for your comment. Recommendation 1.2.2 has now been changed to "If a community multidisciplinary team is involved..." to reflect this point.
	SH	NHS Providers	Short	9	8	We received feedback that the use of the term "community-based multidisciplinary teams" throughout the draft document may risk appearing prescriptive, since many of the functions described are carried out in local areas by other appropriate community or social care teams. This may be employed as a catch-all term to encompass other services such as rapid response or at home services. Members felt it would be helpful if the guidelines explicitly reflected that there are other valid models for supporting people once they are at home. See also p11 l27, p12 l27, p13 l19, p14 l6, p15 l8, p15 l16, p16 l11, p17 l16, p18 l2, p19 l3, p20 l21	Thank you for your comment. The Guideline Committee felt it was important to add 'Community-based multidisciplinary team' to the glossary to demonstrate the range of roles this could cover. In addition the Guideline Committee thought it was important to signpost the Think Local Act Personal definition of "Community health services", which is: "Health services that are provided outside hospitals, such as district nursing".
	SH	Age UK	Short	9	10	Add the following: The multidisciplinary teams must coordinate across all health conditions, incorporating any additional risk and complications that may arise from having a combination of conditions and treatment plans.	Thank you for your comment. In keeping with the overarching principle of person-centred care this recommendation has now been changed to 'If a community multidisciplinary team is involved in a person's care that team should give the hospital multidisciplinary team a contact name. Also give the named

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							contact to the patient and their family or carer". This way the person is not being defined by their illness(es), and their care and support needs are recognised as being specific to the individual.
	SH	Age UK	Short	9	23	Add an additional bullet point: changes in medication. This is crucial given widespread problems with medicines optimisation. NHS England have said about 50% of medicines are not taken as intended and between five and eight per cent of all unplanned hospital admissions are due to medication issues, while another report found "that higher numbers of medicines were associated with a higher likelihood of potentially inappropriate prescribing" (*Polypharmacy and medicines optimisation*, King's Fund 2013).	Thank you for your comment. The Guideline Committee agreed it was important to reflect this point. Recommendation 1.2.3 has now been amended to • daily routines (including the use of medicines and equipment). The NICE guideline on medicines optimisation is also cross referenced in the overarching principles – specifically the section on medicines-related communication and reconciliation during transitions.
	SH	Marie Curie	Short	9	24	(1.2.4) We believe this point would be strengthened if it included a reference to the use of Electronic Palliative Care Coordination Systems (EPaCCS). Benefits of having operational EPaCCS in place are reported to include improved communication and ease of information sharing between professionals involved in a person's care and supporting carers, clinicians, ambulance and out of hours services to make appropriate decisions about a person's care (NEoLCIN, 'EPaCCS in England', 2014). Patients benefit from having their care actively managed and they are more likely to be cared for in their place of choice and less likely to experience unnecessary investigations, interventions and hospital admissions. However, awareness of EPaCCS is still relatively low. For more information see: http://www2.mariecurie.org.uk/Documents/Com	Thank you for your comment and for drawing our attention to the Electronic Palliative Care Coordination Systems (EPaCCS). Unfortunately recommendation 1.2.4 has been deleted in response to other comments that it seemed to encourage making end-of-life care plans too late on in the process. Recommendation 1.2.3 was seen to be more appropriate as it referenced 'end-of-life care' as a point for discussion while drawing up advance care plans. Unfortunately we would have been unable to include your report on Electronic Palliative Care Coordination Systems because it does not meet our inclusion criteria for the evidence review. We are also unable to cross refer to any guidance or recommendation apart from those developed by NICE.

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						missioners-and-referrers/RCGP/EPaCCS-Electronic-systems-that-help-improve-care.pdf.	
	SH	Macmillan Cancer Support	short	9	24	Perhaps more emphasis could be made about use of an advance care planning pro forma here	Thank you for your comment. Unfortunately recommendation 1.2.4 has been deleted in response to other comments that it seemed to encourage making end-of-life care plans too late on in the process. Recommendation 1.2.3 was seen to be more appropriate as it referenced 'end-of-life care' as a point for discussion while drawing up advance care plans.
	SH	SeeAbility	Short	10	14-28	We strongly recommend the list includes sharing of information (before admission and on discharge) about any known infections (relating to the person and the hospital). This is advocated in the Health and Social Care Act 2008 – Code of Practice on the prevention and control of infections, as well as in the NICE public health guideline on prevention and control of healthcare associated infections http://www.nice.org.uk/guidance/PH36	Thank you for your comment. "Care plan" has been added to the list of relevant information to share in 1.3.3. All known infections should be covered by this inclusion.
	SH	United Kingdom Homecare Association	Short	10	3-9	We are not convinced that the use of the word 'wish' is the best option**:** *wish* tends to have childlike connotations that may not resonate with end-of-life care, and would suggest 'preferences' as in s1.4.1 – p12	Thank you for your comment. As a result of various comments the list of bullet points has now been deleted from this recommendation. The Guideline Committee felt that the list risked omitting important points. The edited recommendation is: "Develop and use communication protocols and procedures to support admission."
	SH	Stockton-on-Tees Borough Council	Short	10	1.3.1	These bullet points could be enhanced by including additional issues such as: mental capacity, views of the person & their family, perceived level of need, social networks, level of functioning	Thank you for your comment. As your point suggests, the list could potentially include a multitude of bullet points. For reasons of succinctness, and in order to avoid promoting one aspect over another, the Guideline Committee decided to delete the list on recommendation 1.3.1 altogether.
	SH	The	short	10	1.3.1	Health and social care commissioners MUST	Thank you for your comment. This recommendation has now

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		Patients Association				encourage the use of communication protocols and procedures to support admissions through to discharge. The patient who will be vulnerable and often frightened must not be put in position of repeating information to healthcare professionals. There should also be clear communication with the patients' family who should be 'kept in the loop' as part of the patient's support and care system, as per 1.1.6 and other sections.	been amended to "Develop and use communication protocols…" as feedback suggested that this recommendation should apply to a wider cohort than just health and social care commissioners. Within NICE guidelines 'must' can only be used in a recommendation when it is a legal requirement.
	SH	Royal College of Nursing	Short	10	1.3.1	This should be included in the care plan.	Thank you for your comment. The list has now been removed from this recommendation. The focus is now on encouraging the use of communication protocols rather than their content.
	SH	Royal College of Speech and Language Therapists	Short	10	1.3.2	We are unsure who will be the "admitting team"? Will it be the assigned member of the community multidisciplinary team identified in 1.2.2?	Thank you for your comment. The admitting team refers to any hospital-based practitioners who are involved with the person's admission. This could include the assigned member of the community multi-disciplinary team; however the description has been left intentionally broad in order to account for variance in practice and individualisation involved in person-centred care.
	SH	Royal College of Speech and Language Therapists	Short	10	1.3.2	The RCSLT welcomes the emphasis on communication needs at the point of admission. However, it is questionable if an "admitting team" will be able to identify and address individual's communication needs as they do not receive such training. There is a risk that needs and opinions of individuals with communication needs are assumed, misinterpreted or ignored. Any failure to accurately identify individual's communication support needs will mean that the individual is unable to convey if they are hurt, in pain or distress. This can lead to the person being unable to convey that they are hungry or	Thank you for your comment. The Guideline Committee did not feel that it was appropriate to add speech and language therapists to the admitting team as the evidence did not cover this. The committee also raised concerns that it was unlikely that speech and language therapists would be available to fill this role at the point of hospital admission.

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						thirsty leading to dehydration and malnutrition. Speech and language therapist are trained to assess and treat a range of speech, language and communication problems and their input will be crucial.	
	SH	Royal College of Speech and Language Therapists	Short	10	1.3.3	The RCSLT recommends that 1.3.3 should come before 1.3.2	Thank you for your comment. The Guideline Committee argued that the recommendations flowed better in their original order. 1.3.2 is about identifying needs, 1.3.3 is about transferring information on transfer.
	SH	Royal College of Speech and Language Therapists	Short	10	1.3.3	The RCSLT is pleased that the admitting team will be given information on the individual's communication needs, however it needs to be recognised that many older people who have communication challenges will not have received a speech and language assessment to determine the exact nature of their needs and how to best support them.	Thank you for your comment. 1.3.3 refers to communication needs which are already known. No evidence was located on which to base a recommendation about speech and language assessments on admission.
	SH	Royal College of Speech and Language Therapists	Short	10	1.3.3	Whilst communication passports are mentioned, it is important that staff have knowledge about how to use them and how to communicate effectively. We have received feedback from our members that sometimes the communication passport is left in the individual's bag on transfer/admission and not used.	Thank you for your comment. The recommendations in this guideline strive to avoid scenarios such as this – where the communication passport is not used. Recommendation 1.3.3 encourages all health and social care staff to ensure that this information is handed over at admission.
	SH	Royal College of Speech and Language	Short	10	1.3.3	The RCSLT recommends adding dysphagia (eating, drinking and swallowing needs). Evidence suggests that on older people as many as 68% of people will exhibit signs of dysphagia. People with unmanaged dysphagia have an	Thank you for your comment. The Guideline Committee felt that the bullet point • 'other profiles containing important information about the person's needs and wishes' covered dysphagia. Adding specific conditions to this list risked prioritising certain groups over others which are also likely to

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		Therapists				increased risk of aspiration, pneumonia, nutritional compromise and in some instances death from malnutrition, choking and aspiration. This is particularly important for people who may have non-oral feeding or dietary modified needs.	be at risk.
	SH	Royal College of Nursing	Short	10	1.3.3	It would be helpful if NICE can supply links to good practice examples here?	Thank you for your comment. This recommendation is based on the best available evidence. We are unable to supply links to good practice examples in the recommendations unless they meet the inclusion criteria for the review. Links to best practice and shared learning examples will feature in implementation work for this guideline.
	SH	Sense	Short	10	4	As per comment 1, include the following bullet point in the list: any information or communication needs that the individual (or their parent/carer) has	Thank you for your comment. As a result of various comments the list of bullet points has now been deleted from this recommendation. The Guideline Committee felt that the list risked omitting important points. Offering information in an accessible format that is easy for the person to understand is an overarching principle of the guideline. Likewise, communication needs are highlighted as an important piece of information to pass during the transfer of care.
	SH	NHS Providers	Short	10	10	The requirements to undertake certain tasks “at the point of admission” or “as soon as the person is admitted to hospital” do not allow for differences between elective and non-elective care. For a non-elective admission, urgent or life-saving treatment might be required immediately upon admission, which would prevent staff from fulfilling these requirements until after the treatment has been delivered. We received member feedback that the guideline could benefit from addressing elective and non-elective care separately. See also p11 l25, p12 l14, p15 l8	Thank you for your comment. The Guideline Committee did not feel that it was necessary to distinguish between non-elective and elective admissions because these are recommendations for standardized best practice procedures regardless of whether it is an emergency or not. Prevention of admission to A&E is beyond the remit of the scope for this guideline.
	SH	NHS Providers	short	10	14	We received feedback that this section on the information that practitioners responsible for	Thank you for your comment. Some of the recommendations in this guideline are intentionally aspirational, as you say. The

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						transfers from the community into hospital should provide to the admitting team, is aspirational. While the GP or practitioner may be able to provide some or much of the information listed, in most cases, particularly for emergency admissions, it will not be possible to provide all of this information at the point of admission.	Guideline Committee felt it was important to include recommendations which are desirable even if they are not achievable in every instance. As the guideline is not statutory aspirational outcomes are unlikely to lead to adverse outcomes. The evidence from which the recommendation was derived include a systematic review (Hesselink, 2012 [++]) that found that interventions to improve information exchange at the point of transition from hospital to primary care had a significant effect on care continuity, and a UK views study (Clissett, 2013 [++] which reported that hospital admission would be improved if healthcare professionals conscientiously communicated with carers and engaged them in genuine partnership.
	SH	Age UK	Short	10	14	This paragraph should reference the importance of accurately recording any information received, particularly for people with dementia (this equally applies to anything that happens after the assessment). The National Audit of Dementia (2014) found that while protocols existed in around 95-99 per cent of hospitals for gathering data on patients, rates for then recording in notes were substantially lower: 34 per cent in the case "recurring factors that may cause or exacerbate distress" and 25 per cent for "support or actions that can calm the person if they are agitated". They go on to say this information "could assist in the case of readmission".	Thank you for your comment. There is a recommendation (1.41) which specifically states that information, individual preferences, and medication should be recorded on an electronic data system.
	SH	Sense	Short	10	18	As per comment 1, change bullet to say: communication and/or information needs	Thank you for your comment. Providing information in a format which is easy for the person to understand is an overarching principle of the guideline. As communication and information needs are separate and different issues it was not deemed appropriate to combine this bullet to include information with communication needs.
	SH	Guild of	Short	10	22	The SCR will undoubtedly support the transfer of	Thank you for your comment. The Guideline Committee are

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		Healthcare Pharmacists				medicine information on admission but this is currently not available for all patients admitted in all areas. The ideal would be full read access of primary care records in secondary care. There are only pockets in the country where this is in place. Putting Information Governance aside there is no facility to access some GP systems but we are aware this is being addressed in certain areas.	aware that systems to facilitate access to information across primary and secondary care are not yet available across all UK practice. However, recommendations on medicines reconciliation (including the cross reference to the NICE guideline on medicines optimisation) have been made based on the best available evidence.
	SH	Derbyshire County Council	Short	11 section 1.3.7	general	same point as on pg 9 – is this needed for all?	Thank you for the comment. The Guideline Committee felt that the recommendation was appropriate because it is qualified by saying that the team should reflect the person's needs. This means that the team can be as small or large as required depending on the circumstances.
	SH	United Kingdom Homecare Association	Short	11	15-23	We are concerned that this level of detail may not add value to the guidelines	Thank you for your comment. The Guideline Committee, in contrast, felt that it was extremely important to have accurate and specific examples of reasonable adjustments that should be made for those at risk of less favourable treatment. The examples have been reviewed and amended slightly and the Guideline Committee are confident both that the examples are realistic and that they should remain in the guideline.
	SH	SeeAbility	Short	11	15-23	We also strongly recommend that the admitting team has early dialogue to establish the level/type of support required during admission, who will provide it and how this will be funded. SeeAbility cannot always provide one to one support for the duration of an individual's hospital stay, which can leave someone with complex needs very vulnerable due to hospital resources/expertise in their specific needs. There seem to be mixed experiences: some hospitals expect a social care provider's staff to remain present (and they or the local authority may fund this - or there is no money available	Thank you for your comment. Ensuring that information and communication needs are recorded and met is an overarching principle of the guideline. In recommendation 1.3.6 'providing communication aids' is given as an example of a reasonable adjustment which should be made when there is an identified need.

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						despite that expectation); and some do not want our staff present as they are the regulated provider during the hospital stay and to have our staff providing person care/moving and handling can present accountability/insurance issues. These are areas which clearly cause issues for the transition and care of people with complex need and it would be good to see this recognised in the guidance.	
	SH	Royal College of Surgeons	Short	11	18-23	Additional patient groups that should be considered: • Requirements for support with feeding during stay • Those at high risk of falls • Confused patients requiring one to one supervision • Patients that move between different hospital specialties • Those with psychological requirements- there is evidence that many elderly patients admitted with medical conditions have untreated depression which may impact on discharge	Thank you for your list of suggested additions to recommendation 1.3.6. The Guideline Committee revised and amended the examples on this recommendation in order to make them more specific and accurate. The list is not meant to be exhaustive and, while recognising the legitimacy of your points, they did not feel it was possible to include so many additional examples without risk of omitting other vulnerable groups.
	SH	Royal College of Nursing	Short	11	1.3.5	Provision must be made for financial discussions within the integrated care arena and patients should know when they will be visited by a social worker. Discussions of a financial nature can be undertaken by nurses and other members of the multiagency team- it is the most complex who requires the social workers intervention. People and their caregivers should be given this information in the setting in which they require	Thank you for your comment. The guideline recommends that hospital and multidisciplinary teams should work together to address the need for assessments for eligibility for health and social care funding under the 'Discharge Planning' section in 1.5.13.

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						this- this may be hospital or their own homes.	
	SH	Royal College of Nursing	Short	11	1.3.5	People with learning disabilities often have more significant stakeholders, perhaps this should this include their carers and care workers, and based on the Care Act, their Advocate?	Thank you for your comment. The Guideline Committee agreed to change the recommendation to also include 'carer' and 'advocate' in light of your comment.
	SH	Royal College of Speech and Language Therapists	Short	11	1.3.6	The list of reasonable adjustment and further support should include any communication aids or equipment commonly used by individuals with communication needs. Furthermore, any adjustments to communication, communication styles and strategies should be included.	Thank you for your comment. Recommendation 1.3.6 has been changed to reference the Equalities Act 2010 and the examples now give more accurate and specific examples of reasonable adjustments, including communication aids.
	SH	Royal College of Nursing	Short	11	1.3.6	Frailty and dementia should be highlighted as something that needs reasonable adjustment due to prevalence in this group of patients.	Thank you for your comment. Recommendation 1.3.6 has been changed to reference the Equalities Act 2010 and the examples now give more accurate and specific examples of reasonable adjustments. We cannot make an exhaustive list of all reasonable adjustments, and without the appropriate evidence we cannot make condition-specific recommendations.
	SH	Royal College of Nursing	Short	11	1.3.6	Confidential Inquiry into Premature Deaths of People with learning disabilities http://www.bristol.ac.uk/cipold/ recommends 'reasonable adjustments' action plans for people with learning disabilities using acute hospital services. Our members have made reference to the East Kent Hospital University Foundation Trust's 4C framework for making Reasonable Adjustments (in print), for more details see www.ekhuft.nhs.uk/learningdisabilities	Thank you for your comment. Whilst we recognise this as a key issue the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD) - Final report was not retrieved in the searches as it was not indexed as being specifically about admission/ discharge in the controlled indexing terms or title and abstracts. Please note that recommendation 1.3.6 now references the Equalities Act 2010.
	SH	Royal College of Speech and Language	Short	11 -12	1.3.7	The RCSLT is unsure why the hospital multidisciplinary team not include a speech and language therapist? We feel that this is oversight based on the emphasis given to appropriate and relevant communication. Only a speech and language therapist is able to accurately identify	Thank you for your comment. Recommendation 1.3.7 now describes the composition of the team as including • therapists. Therapist has been pluralised so it now covers speech and language therapists as well as physio- and occupational therapists. We try to avoid writing exhaustive lists to keep the

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		Therapists				someone's communication difficulties and the provide strategies to allow them to communicate their wished and needs. Furthermore, only a speech and language therapist can assess an individual's eating, drinking and swallowing abilities, failure to do this will lead to chest infections, aspiration, pneumonia and unnecessary admission to hospital. Either speech and language therapists should be added to the list or clearly included in "specialists in the person's conditions".	recommendations as concise as possible; the Guideline Committee considered 'therapists' to cover the intended range.
	SH	Royal College of Nursing	Short	11	1.3.7	The term *hospital social worker* is outdated and does not reflect integration.	Thank you for your comment. The Guideline Committee agreed with your point and changed 'hospital social worker' to 'social worker' in this recommendation.
	SH	Royal College of Nursing	Short	11	1.3.7	Relating to the 'Community Based Multidisciplinary team' Who would this be? The local specialist team, or a newly created specialist role similar to the later recommended Hospital Discharge Coordinator?	Thank you for your comment. The Guideline Committee decided it was important to include a definition of the Community Based Multidisciplinary team in the glossary. It is not possible to be too prescriptive when describing the exact composition of the team as ideally this would reflect the needs of the individual receiving care.
	SH	Derbyshire County Council	Short	11	8	could the language reflect setting the expectation about when it is anticipated they will leave as opposed to how long they will stay?	Thank you for your comment. The phrase 'how long they might need to be in hospital' in recommendation 1.3.5 was felt to be neutral and not overly-focussed on either the length of hospital stay *or* the time until discharge. Considering that another bullet on this recommendation focuses specifically on hospital discharge: • how they might get home when they are discharged from hospital it was not deemed appropriate to re-word this point.
	SH	Sense	Short	11	18	As per comment 1, include the following bullet point in the list: arrangements for communication support (e.g.a British Sign Language interpreter)	Thank you for your comment. The examples in 1.3.6 have been changed to give more accurate and specific examples of reasonable adjustments. The second bullet now reads:

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						have been made as required.	"providing communication aids (this might include an interpreter)." Rather than specifying specific conditions (or types of interpreters) the example has been left intentionally broad so as not to give precedence to one particular group over another.
	SH	Marie Curie	Short	11 -12	30-9	(1.3.7) We understand that the list of possible MDT members is not intended to be exhaustive; however, we suggest that including a 'member of the palliative care team' in this list would help to promote access to palliative care services for people with palliative needs but low levels of access. This is particularly true for people with terminal or incurable illnesses other than cancer, e.g. dementia, and those who may benefit from palliative care despite not being at the end of life, e.g. people with multiple sclerosis (MS). Research shows that appropriate provision of palliative care can improve people's quality of life, reduce symptom burden and result in fewer hospital admissions, meaning it could support a more successful transition from inpatient to community care and prevent readmission. Marie Curie's 2015 report 'Triggers for Palliative Care' (p. 20) demonstrates the need for a dynamic model of episodic palliative care involvement for people with conditions such as MS, with involvement triggered by events such as a hospital admission. However, awareness of the palliative care team from other professionals may be quite low.	Thank you for your comment. The Guidance Committee felt that "specialist in the person's condition" covered a member of the palliative care team. Furthermore, there is a specific section in the guideline on 'Discharge planning for end-of-life care needs' which includes a recommendation to ensure that people needing end-of-life care are offered both general and palliative care services.
	SH	NHS Providers	short	11	25	In practice, hospital-based multidisciplinary teams are normally already established before the admission of an individual to hospital, and different/specific teams would not usually be formed around each individual service user unless that person has multiple complex	Thank you for your comment. The guideline is aimed at people with social care needs who may well have complex, specific care needs. The recommendation about the composition of the community and hospital-based multidisciplinary teams is qualified by the phrase 'reflect the person's needs and circumstances'. It does not suggest that the team should

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						conditions or complex specific care needs and/or circumstances.	always be restructured for each individual, but that when specific needs are identified the composition of the team should reflect this.
	SH	Stroke Association	Short	11	30	The recommended professionals that a multi-disciplinary team could include should list speech and language therapists as access to these professionals is vital for stroke patients due to the fact that 33% of patients experience problems with communication, yet SSNAP data shows that access to these professionals is limited and variable across the country. They should be an important component of the core team for a stroke patient and are included in the Stroke Rehabilitation NICE Clinical Guidance for core team membership of a stroke multi-disciplinary team.	Thank you for your comment. Under the section 'Establishing a hospital-based multidisciplinary team' recommendation 1.3.7 now describes the composition of the team as including • therapists. Therapist has been pluralised so it now covers speech and language therapists as well as physio- and occupational therapists
	SH	SeeAbility	Short	12	14-19	This section should encourage the involvement of the person's family, carers and independent advocates to support anyone who has difficulty retaining and understanding information.	Thank you for your comment. Involving families and carers in care (where consent is given), and potentially providing access to advocacy for those at risk of less favourable treatment (such as those with communication difficulties) are both overarching principles of the guideline. Recommendation 1.4.1 also highlights the importance of recording multidisciplinary assessments, medication and individual preferences on electronic databases.
	SH	Action on hearing loss	Short	12	20-23	Recommendation 1.1.5 should make reference to the Accessible Information Standard which states that robust systems should be in place for recording a person's information needs or contact preferences, which either automatically generate information or correspondence in the required format or prompt care staff to make alternative arrangements. The recommendation should also give examples of translated material. People who are deaf who	Thank you for your comment and for drawing attention to this important document. This recommendation in the overarching principles section now links directly to the Accessible Information Standard.

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						also use British Sign Language (BSL) may require BSL translation of written material either through a qualified BSL interpreter or BSL video translation (where a BSL translation of written or typed information is recorded on video).	
	SH	Royal College of Surgeons	Short	12	10-12	Recognition that in an emergency admission, where the patient has deteriorated such that they will not automatically be able to return to the same discharge destination, this is likely to take much longer and delay discharge	Thank you for your comment. The Guideline Committee did not feel that the recommendation needed rewording as they did not see that any kind of timeframe was implied in this recommendation.
	SH	Royal College of Surgeons	Short	12	25-27	This seems idealised and not practical for all services at present- not every service has electronic patient records	The GC agrees that resolving data sharing and electronic data systems is a challenging area and that this recommendation will be difficult to implement. However the GC believes recommendation 1.4.1 is realistic given the recent advances being made in this area. For example 96% of patients registered with a GP practice in England now have a Summary Care Record, which contains information including prescribed medications. The Committee also concluded that since these recommendations are not statutory, it was appropriate to leave this recommendation as it is.
	SH	Royal College of Surgeons	Short	12	25-27	The availability of electronic ability of hospital pharmacists to communicate directly with community pharmacists, would be a massive support to improved efficiency in discharge planning	Thank you for your comment. Relaying accurate information to community pharmacists and GPs (and ensuring consistency among all hospital-based and community-based staff) is a key intention of this recommendation. Electronic records would prevent people from having to retain and repeat information on numerous occasions.
	SH	Action on hearing loss	Short	12	7-9	We welcome the inclusion of "people with communication difficulties" in the examples of people at risk of less favourable treatment or less access to services. People with hearing loss face significant barriers when accessing health and social care and this should be taken into account when planning transitions between services.	Thank you for your comment. People with communication difficulties and/ or sensory impairment were identified as a group at risk of poor transitions within the Equalities Impact Assessment for this guideline. However, please note that the purpose of the guideline is to focus on principles of transitions rather than specific conditions. Communication difficulties brought about through • hearing loss, which can be exacerbated through

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						People with hearing loss are at risk of less favourable treatment in care homes. Our research A World of Silence[5] suggested that large number of care home residents have undiagnosed hearing loss. Many residents had not addressed their hearing loss. The care staff we interviewed admitted that hearing loss was sometimes overlooked compared with other issues such sight loss, pain or safeguarding. Some care staff did not know about hearing loops and other assistive equipment such as amplified telephones and TV listeners. Others lacked the training to carry out basic hearing aid maintenance. Our research Access All Areas[6] shows that people with hearing loss often struggle to access their GP, because of a lack of other options such as online booking, SMS or text relay. One in seven (14%) had missed an appointment because they didn't hear their name being called in the waiting room. Once in the appointment, alarmingly more than a quarter (28%) said that they didn't understand their diagnosis and one in five (19%) were unsure about their medication. The situation is even worse for people who are profoundly deaf, for many of whom British Sign Language (BSL) is their first language not English. Research also shows[7] around two thirds of BSL users (68%) do not get a BSL	age • learning disabilities • or among people for whom English is not their first language were all identified as causing problems in accessing services and negotiating the complicated interface between hospital and social care.

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[5] Echalier, M (2012). A world of silence. Available at: www.actiononhearingloss.org.uk/aworldofsilence
[6] Ringham,, L. (2013). Access all areas. Available at: www.actiononhearingloss.org.uk/accessallareas
[7] http://www.actiononhearingloss.org.uk/get-involved/campaign/equal-treatment/the-problem/survey-of-bsl-users.aspx

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						interpreter when they ask for one and almost half of those who do get an interpreter find the quality of interpretation is not good enough.	
	SH	Action on hearing loss	Short	12	17-19	Recommendation 1.1.4 should make reference to NHS England's Accessible Information Standard which states that communication support must be made available to people with sensory loss or learning disabilities to ensure they able to participate fully in discussions about their care. Examples of communication support for people with hearing loss include - Hearing loops - transmit sound through magnetic field to a hearing aid to improve speech clarity and understanding. These need to be maintained and switched on. - Speech-to- text reporters – type verbatim (word for word) accounts of what is being said and the information appears on screen in real-time for users to read. - Notetakers – produce a set of notes for people who can't take their own because they are lipreading or watching a British Sign Language (BSL) interpreter. They are most commonly used in schools, colleges and universities, but also at work, on training courses and at other events. An electronic notetaker takes notes using a laptop whereas a manual notetaker takes handwritten notes. If the person lipreads, care staff should ensure the room is well it and they face the person whilst speaking. They should speak clearly and	Thank you for your comment. In line with your suggestion recommendation 1.1.6 now links directly to NHS England's Accessible Information Standard. Recommendation 1.3.6 also gives the example of providing communication aids (including an interpreter) as a reasonable adjustment that could be made by the admitting team to accommodate the person in hospital.

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						slowly, and avoid obstructing their face with their hands or other objects. People who are deaf who use BSL are likely to require a BSL interpreter, and all BSL interpreters booked must be registered with the NRCPD and qualified (see Accessible Information Standard). Consultations may need to be longer than usual to accommodate communication needs. For example, when information is relayed through BSL interpreter, both parties may require more time to understand what is being said.	
	SH	Age UK	Short	12	1	Add an additional bullet: Geriatrician.	Thank you for your suggestion. Rather than detailing every possible role in the team it was felt that 'geriatrician' was covered by 'specialists in the person's conditions'. We try to avoid writing exhaustive lists to keep the recommendations as concise as possible.
	SH	Stockton-on-Tees Borough Council	Short	12	1.3.10	The use of the word "geriatric" seems outplaced in modern terminology and creates a negative impact on the assessment process.	Thank you for your comment. The Guideline Committee felt that the terminology used in the review evidence and their own experience backed up the use of the phrase 'Comprehensive Geriatric Assessment'. While 'geriatric' has derogatory connotations, 'geriatrician' is still the primary terminology used for specialists in the care of aged people.
	SH	The Patients Association	short	12	1.4	During hospital stay, the patient's well-being could be helped by allowing members of the family or community be present or help with 'care', though only in an appropriate fashion and with the consent of both them and the patient. However, friends, families and carers should never be expected to substitute for the input or expertise of a required healthcare professional.	Thank you for your comment. Involving families and carers in discussions about care (if the person gives consent) is an overarching principle of the guideline. There is also a section on 'support and training for carers'. In order to avoid over-burdening carers, 1.5.31 recommends that hospital-based multidisciplinary team should take account of carer's willingness and ability to provide support and particular circumstances when discharge planning.
	SH	Royal College of	Short	12	1.3.19	As above : Is this statement required? If patient groups are going to be focussed on, does this need an addendum or appendix for each of the	Thank you for your comment. Recommendation 1.3.9 is aimed at people with complex needs because the evidence related directly to this population. It is not possible to add addendums

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		Nursing				patient groups?	for other patient groups because the review did not furnish evidence on any other groups.
	SH	Royal College of Nursing	Short	12	1.3.7	Should this list include the Hospital Based Learning Disability Specialist Nurse or Safeguarding Practitioner?	Thank you for your comment. The Guideline Committee felt that 'specialists in the person's conditions' covered these roles.
	SH	Royal College of Nursing	Short	12	1.3.8	Is this statement required? If patient groups are going to be focussed on, does this need an addendum or appendix for each of the patient groups?	Thank you for your comment. Recommendation 1.3.8 was derived from evidence which related specifically to an 'older people' population. Mudge et al. 2012 related to patients admitted from residential aged care and Eklund et al. 2013 looked at frail, older people.
	SH	Crisis	Short	12	1.3.9	For people who are homeless, housing must be a key priority when discussions about discharge planning start. Where the person is discharged to is extremely important for those who have no secure home. It must be a key priority for the hospital multidisciplinary team and should be explicitly stated in this paragraph.	Thank you for your comment. Identifying and addressing homelessness as part of planning for a safe and timely transfer of care is covered in recommendation 1.5.13. There is also a recommendation for the discharge coordinator to liaise with the local authority housing options team if a person is homeless (1.5.28).
	SH	Sense	Short	12	8	As well as specialists in the person's medical condition the team should include specialists able to advise on the impact of the condition on independent living and the support a person needs on discharge. For instance, if a person is deafblind, a specialist with understanding of the type of support and reablement required is more important than a person with understanding of the specific eye condition.	Thank you for your comment. The guideline makes repeated references to ensuring that the person's support needs are identified, recorded and met.
	SH	Macmillan Cancer Support	short	12	14	Again more emphasis about use of ACP especially in relation to any expressed preference about place of care or death	Thank you for your comments. Advance Care Planning is covered in 1.2.3, where there is a specific reference to discussing end-of-life care.
	SH	NHS Providers	short	12	16	These three sections could make reference to alternative assessment and discharge processes which providers are increasingly piloting and adopting, such as "discharge to assess". Several members who fed back to us	Thank you for your comment. The NICE recommendations have been developed on the basis of the best available evidence of effectiveness, cost effectiveness, views and experiences and the expertise of the Guideline Committee as well as expert witness testimony.

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						raised the fact that the guidelines do not take discharge to assess models into account, and said it would be helpful if the guidelines referred to such alternative models. See also p15 l15, p17 l11, p17 l14	The model of transfer from hospital, known as 'discharge to assess', which has been initiated in various UK locations, was identified as a major gap in the evidence. The Guideline Committee were unable to make practice recommendations about this new and evolving model because to date, no research evidence has been published which meets the criteria for inclusion in the review and presentation of evidence. For information on the types of evidence included in the research review, please see appendix A of the guideline. However, having identified a gap in the evidence the Guideline Committee put forward aresearch recommendation for "Assessment at home to improve hospital discharge success rates".
	SH	Macmillan Cancer Support	short	12	20	It would be helpful to specify what is to be included as part of a comprehensive geriatric review.	Thank you for your comment. Comprehensive Geriatric Assessment has now been defined in the glossary as "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."
	SH	NHS Providers	short	12	20	Hospital staff will only need to start a comprehensive geriatric assessment if the person has not already been assessed in the community or during a previous admission to hospital. It may be more appropriate to require staff to" refer to" the assessment of the person's needs, and to start an assessment if one has not already been carried out.	Thank you for your comment. Recommendation 1.3.9 advises on this exact scenario: "If assessments have already been conducted in the community, refer to the person's existing care plan."
	SH	Age UK	Short	12	21	We believe the phrase "complex needs" is vague and too subjective. Consider in addition using the word "frailty", with the definition included in the NICE final guidance: "Disability, dementia and frailty in later life - mid-life approaches to prevention". The word should not be used directly with patients (see research	Thank you for your comment. The guideline will signpost to the Think Local Act Personal Jargon Buster definition of 'complex needs': "You may have complex needs if you require a high level of support with many aspects of your daily life and rely on a range of health and social care services. This may be because of illness, disability or loss of sight or hearing - or a combination of these. Complex needs may be present from

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						Frailty: Language and Perceptions, BritainThinks for Age UK/BGS 2015). Alternatively, settings should consider following guidance from *Quality care for older people with urgent & emergency care needs* (British Geriatrics Society et al), the "Silver Book", for identifying frailty.	birth, or may develop following illness or injury or as people get older".
	SH	Age UK	Short	12	22	Additional paragraph: Involve the individual, their carer and/or family in setting specific care goals. This should include reference to needs that are not necessarily connected to the reason for admission.	Thank you for your comment. The Guideline Committee felt that this was already covered by other recommendations on involving patients and families in discussions about their care, and on assessment of needs and identifying potential barriers to discharge.
	SH	Age UK	Short	12	23	See again point 6 above on recording information on people with dementia.	Thank you for your comment. As the recommendation covers all groups, it was not deemed appropriate to highlight any one condition over another.
	SH	Guild of Healthcare Pharmacists	Short	12	25	We are not sure how accessible most e-Prescribing systems are outside of a hospital Trust site. This could be a barrier to community teams but if it is 'care plans' that are being referred to within this section then prescribed medicines for inpatients generally don't tend to be needed externally during admission of a patient unless it is for the imminent transfer.	Thank you for your comment. The recommendation about the electronic data system was intended to be aspirational. 'Ensuring health and social care practitioners communicate effectively' is one of the challenges for implementation and will be given due consideration.
	SH	NHS Providers	short	12	26	The guidelines do not acknowledge the substantial challenges involved in creating, maintaining and sharing electronic patient records, in particular between acute and community or social care settings. These services frequently use different systems which are not always interoperable and in practice this requirement may be impossible to meet in some local health systems at the present time. All members who provided us with feedback highlighted that work is underway to improve systems integration, but they would welcome an acknowledgement in the guidelines of the challenges they currently face in this area.	Thank you for your comment. We recognised the challenges that sharing patient records involves. The recommendation about the electronic data system was intended to be aspirational. Also, please note that 'Ensuring health and social care practitioners communicate effectively' is one of the challenges for implementation and will be given due consideration.

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	SH	United Kingdom Homecare Association	Short	13	General	We would suggest that a useful recommendation for the management of discharge from hospital could be undertaken by a dedicated person using a Key Account Management (KAM) approach – probably best employed by a Health & Wellbeing Board or a CCG	Thank you for your comment. Recommendations in the 'Discharge from hospital' section are based on the best available evidence which showed the benefits of having a single individual coordinating people's discharge from hospital. The Guideline Committee were unanimous in their support for this, but they decided against stipulating exactly how hospitals should allocate the role.
	SH	Royal College of Nursing	Short	13	1.4.2/3	Our members commented that people with learning disabilities often have carers or care workers with them for some of their admission. They consider that the roles of these staff and ward staff ought to be negotiated.	Thank you for your comment. Please note that the focus of the guideline was on general principles of transition and recommendations were only made on specific conditions where there was specific evidence. The systematic review did not furnish any evidence on this area and as such the Guideline Committee were unable to make any recommendations.
	SH	Royal College of Nursing	Short	13	1.4.2/3	Our members consider that bed side handovers would be a relevant recommendation here for these patients and their carers / care workers.	Thank you for your comment. Unfortunately no evidence on bedside handovers materialised from our evidence search so the Guidelien Committee could not make a direct recommendation concerning them.
	SH	Royal College of Nursing	Short	13	1.4.4/5	Is this statement required? If patient groups are going to be focussed on, does this need an addendum or appendix for each of the patient groups?	Thank you for your comments. The Guideline Committee made these recommendations based on evidence which was specific to older people with complex needs (1.4.4) and stroke patients (1.4.5).
	SH	Action on hearing loss	Short	13	19-26	A line should be added to recommendation 1.2.3 to include requirements for communication support. For example, "need for communication support and/or equipment such as hearing loops, notetakers, speech-to-text reporters qualified BSL interpreters". The guideline needs to be clear on the difference between communication support (which is a reasonable adjustment required to assist two way communication for people with specific communication needs) and an advocate (who provides support in decision making and	Thank you for your comment. Recommendation 1.3.6 now highlights that the admitting team must identify whether there is a need to make reasonable adjustments to accommodate people in hospital in line with the Equalities Act 2010. The first example given of a reasonable adjustment is the provision of communication aids, such as interpreters. Recommendations concerning advocacy are presented separately.

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						expression of views).	
	SH	Action on hearing loss	Short	13	5-10	Recommendation 1.2.1 should be reworded to include communication needs. For example "this should include contingency planning to help them manage their health condition and meet their communication needs during their stay in hospital". This would bring the recommendation in line with the Accessible Information Standard which states that a person's communication needs must be identified, recorded, met and shared between health and social care organisations as part of routine referral, discharge or handover procedures.	Thank you for your comment. The Accessible Information Standard is now referenced in 1.1.6 within the overarching principles of the guideline. The provision of communication aids to accommodate someone during their hospital stay is also given as an example of reasonable adjustment in line with the Equalities Act 2010.
	SH	United Kingdom Homecare Association	Short	13	22-25	is not clear who 'they' refers to	Thank you for your comment. The Guideline Committee agreed that this recommendation should be reworded in light of your feedback. The second sentence has been amended to "The discharge co-ordinator should be.." for clarification.
	SH	SeeAbility	Short	13	1-3	SeeAbility would like to see improved consistency in information sharing between shifts. We have experienced providing hospital passports/training/communication passports containing vital information to go regularly astray/not be communicated between shifts. We feel the issue of shift information needs more emphasis, at present this is only about review of information on progress towards discharge at handover.	Thank you for your comment. The guideline encourages health and social care practitioners across community and hospital-based teams to develop and use communication protocols. A raised awareness at all point in the process should feed into improved consistency in information sharing between shifts as well as at the points of transfer of care.
	SH	Action on hearing loss	Short	13	1-3	Recommendation 1.1.6 should be reworded to include requirements for accessible information. For example, "Give people information about their diagnosis and treatment when they are	Thank you for your comment. In light of your feedback recommendation 1.1.6 now has a direct link to the Accessible Information Standard.

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						being transferred between hospital and home and ensure this is communicated in a way the person can understand". Under the Accessible Information Standard health information must be accessible for people with sensory loss or learning disabilities. For people with hearing loss, information must be available in written form. For some people who are deaf who use BSL, English may be their second language, therefore it is important that all information is written in plain English and easy to understand. Where there is complex text, BSL translation of health information may be required either through a qualified BSL interpreter or BSL video translation (where a BSL translation of written or typed information is recorded on video).	
	SH	Royal College of Surgeons	Short	13	6-7	We would strongly endorse that there needs to be joint care with Geriatric Medicine	Thank you for your support. The Guideline Committee agrees with you about the importance of geriatric medicine and this is supported by the evidence. Recommendation 1.4.4 is derived from good quality effectiveness evidence that specialist geriatric care and geriatric assessment, which commences on admission to hospital has a positive impact on experiences and outcomes for older people. It is also based on a high quality systemic review and meta-analysis which suggests that comprehensive geriatric assessment and care provided on specialist units was likely to be cost-effective compared with non-specialist care.
	SH	Royal College of Surgeons	Short	13	12-13	Ensure patients are admitted with equipment they would normally use e.g. wheelchair, walking stick, glasses, hearing aid and this is then returned with the patient on discharge	Thank you for your comment. Recommendation 1.2.3 has now been amended to include 'the use of medicines and equipment'.
	SH	Derbyshire County Council	Short	13	4-5	can you detail who you mean when referring to 'people' i.e. hospital and community based MDT, patient, carers, relatives?	Thank you for your comment. Recommendation 1.4.3 has now been reworded to "any changes to *their* plans for transfer" in order to clarify that the person being referred to is the patient.

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	SH	NHS Providers	short	13	1	It may not be appropriate in all cases to review and update a person's progress towards discharge at every shift handover and ward round – particularly if the person is expected to be in hospital for a substantial length of time, it may not be relevant or practical to update their progress this frequently. This requirement could be more flexible to allow for case-by-case decisions.	Thank you for your comment. The Guideline Committee reasoned that as person-centred care is an overarching principle of the guideline it was implicit that reviews at shift handover would be conducted on a case-by-case basis.
	SH	The Patients Association	short	13	1.5	On discharge from hospital, the Patients Association agrees that there should be a named designated discharge coordinator who should be the central point of information to the patient, their families and to other healthcare professionals that enables the discharge plan.	Thank you for your comment and for your support of our recommendation to create a designated discharge coordinator post.
	SH	Royal College of Nursing	Short	13	1.4.2	This section identifies the need to keep hospital staff up to date with plans regarding discharge, our members consider that the community team should also be kept in the loop regarding the discharge plans. Discharge planning for complex individuals need to be discussed as soon as possible with community / primary care colleagues. This is often a reason for delayed attendance and also hospital readmissions	**Covered b** Thank you for your comment. Recommendation 1.5.5 identifies the need to share assessments and updates on the person's health status with the community multidisciplinary team during discharge planning.
	SH	Royal College of Nursing	Short	13	1.5.1	Could this role be in integrated care? Should they prioritise particular patient groups?	Thank you for your comment. 1.5.1 does not endorse prioritising particular patient groups, but rather recommends that the discharge coordinator (or appointed person responsible for discharge) is selected according to the person's needs. This is in line with the overarching principle of person-centred care. The Guideline Committee chose not to stipulate from which team the discharge coordinator should be appointed because, again this will differ depending on the needs of the individual and the way in which staffing is organised at the local level.

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	SH	The Patients Association	short	13	1.4.3	This section is unclear – the Patients Association agrees that practitioners should keep people regularly updated about any changes to plans for a person's transfer from hospital, but ask that the text is amended to make clear that 'people' include family members or friends of the patient who may need to prepare for hospital discharge and for care of the patient back at their home.	Thank you for your comment. The Guideline Committee agreed that this recommendation should be reworded in order to clarify its meaning. It has been changed to: "Hospital-based practitioners should keep people regularly updated about any changes to their plans for transfer from hospital."
	SH	City of York Council Adult Social Services	Short	13	1.4.4	**'Geriatrician / geriatric'** – is this term still in general use? Could Older Person / Older person specialist be used?	Thank you for your comment. The Guideline Committee felt 'geriatrician' was the most appropriate word. This decision was based on the evidence from which the recommendations were derived and from their own experience of current practice.
	SH	Royal College of Nursing	Short	13	1.5.3	Discharge Planning Protocols – Does this guidance need to make a distinction between 'medically fit for discharge' and 'safe to go home'?	Thank you for your comment. This recommendation was based on the best available evidence alongside guideline committee consensus. No evidence materialised which discussed these phrases and the Guideline Committee did not include them in any of the recommendations.
	SH	Royal College of Speech and Language Therapists	Short	13 17	1.4.5 1.5.26	Whilst we support early support discharge (ESD) teams to facilitate discharge, our members report that ESD for Stroke is still not available countrywide. We would welcome more information on how this will work in practice.	Thank you for your comment. We recognise variation in the availability of ESD for stroke around the UK. We will be seeking practice examples of ESD for shared learning.
	SH	City of York Council Adult Social Services	Short	13	1.4.6	We support the suggestion that '**people are encouraged to follow their usual daily routines as far as possible'** when in hospital but this may require a fundamental change to the way some hospital wards organise their routines. It will also require more communication with the person themselves and care givers and other family members to	Thank you for your comment. This recommendation was intended to be aspirational so if hospital wards have to re-organise their routines to allow people to follow their daily routines as a consequence that would a positive outcome. It is also qualified by the ending 'as far as possible' so as to keep it realistic.

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						understand what those daily routines are.	
	SH	Sense	Short	13	3	As per comment 1, insert the following additional point: Record any information and communication needs and ensure that they are appropriately flagged on both paper based and electronic record keeping systems (as per SCCI 1605). This information should be shared and included as part of each shift handover to ensure that effective and appropriate communication is maintained.	Thank you for your comment. Information and communication needs will be recorded as part of the care plan.
	SH	Royal College of Nursing	Short	13 -14	1.4.4 & 1.5.6	These should state 'clinician' rather than *geriatrician/hospital based doctor* to reflect the roles of other healthcare professionals such as consultant nurses and Allied Health Professionals (AHPs) who are also involved in the care of the patient.	Thank you for your comment. 1.4.4 uses "geriatrician-led" because this was taken directly from the evidence. Recommendation 1.5.6 intentionally highlighted one role - 'hospital-based doctor' - to be solely responsible for sending the discharge summary to the GP. Even though others are likely to be involved in the person's care the Guideline Committee felt it was important that one person was accountable to avoid shunting of this responsibility.
	SH	Age UK	Short	13	4	This line should read: Hospital-based practitioners should regularly update the person they are caring for and their carers, where appropriate	Thank you for your comment. Involving carers and keeping them informed (where consent is given) is covered by the overarching principles (1.1.3).
	SH	Macmillan Cancer Support	short	13	7	Macmillan understands there are capacity issues within geriatric services that may make the provision of complex care in specialist units a challenge to deliver.	Thank you for your comment. The Guideline Committee considered that these were important recommendations to make base on the evidence considered. The recommendations are intended to be aspirational.
	SH	SeeAbility	Short	13	7	This section provides another opportunity to reinforce the need to identify what resources/expertise are needed to meet the needs of someone with visual impairment, learning disabilities and other complex needs during an inpatient stay. A focus on learning disability would be welcome, as well as stroke and geriatric services, so for example there should be involvement of a Learning Disability Liaison post, if the hospital has one, to support	Thank you for your comment. We recommend that a 'specialist in the person's condition' makes up part of the hospital-based multidisciplinary team. Unless there is specific evidence to back it up the Guideline Committee have refrained from making condition-specific recommendations.

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						people throughout their stay.	
	SH	Age UK	Short	13	7	See point 8 above on frailty.	Thank you for your comment. The Guideline Committee decided not to add the term 'frail' to recommendation 1.4.4 because the evidence underpinning this recommendation did not specify 'frail older people'. Instead, the evidence of effectiveness and cost effectiveness focussed on 'older people'. We have now clarified what we mean when we refer to older people in this guideline.
	SH	Airedale NHS Foundation Trust	short	13	9	Early supported discharge for stroke patients is still not available in all areas.	Thank you for your comment. We hope the recommendation will be a stimulus for change so it is adopted more widely.
	SH	Stroke Association	Short	13	9	SSNAP data (July 15) shows that almost 20% of patients are admitted initially to a general ward and only 53.6% are directly admitted to a stroke unit within 4 hours. Therefore it's essential that every opportunity is taken to support the principle of treating people in a stroke unit and we are pleased that the recommendation to treat people affected by stroke in a stroke unit is included in the guideline.	Thank you very much for your comment. We are pleased that you support this recommendation.
	SH	Airedale NHS Foundation Trust	short	13	12	Supporting patients with usual daily routines is challenging, particularly in large busy wards. The promotion of self medicating is an example of this, and would contribute to compliance with medication after discharge, however is challenging in the wards when considering safe storage etc.	Thank you for your comment. This recommendation does not make a direct reference to self-medication as a part of maintaining a daily routine in hospital.
	SH	Royal Pharmaceutical Society	Short	13	12	Enabling people to self medicate when in hospital encourages them to follow their usual daily routines and also supports them to get used to any changes made to their medicines whilst in hospital.	Thank you for your comment. While this recommendation (1.4.6) does not make a direct reference to self-medication during the hospital stay, the NICE guideline on medicines optimisation is cross referenced in the 'Communication and information sharing' section. The medicines reconciliation section of this guideline recommends that people (and their carers, where appropriate) are involved in their own medicines

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							reconciliation.
	SH	Age UK	Short	13	13	Add at the end of the line: This may include: - When they normally take their medication - Mealtimes and preferences wherever possible - Socialising - Exercise wherever possible	Thank you for your comment. The Guideline Committee did not add any examples to this recommendation as they wanted to keep it deliberately broad.
	SH	SeeAbility	Short	13 General	14	We support the concept of an identified discharge co-ordinator, as coordination is not always a good experience. However it is important that the coordinator has an understanding of the circumstances someone is returning to. SeeAbility has had particular problems with hospitals thinking residential care homes can meet changed health needs or that our supported living services are residential homes with 24 hour provisions (when the person may only be funded for 10 hours support/week) and just discharge people regardless. A current example we have is a person we support who had a leg amputated and is assessed as medically fit for discharge. She is assessed to have capacity and states she wants to get home as soon as possible. She lives in a first floor flat with no lift. She is not mobile. She has a very small support package and her needs have substantially changed. If she returned home without due planning, she would be isolated/restricted to her own four walls and would be at risk of deteriorating health if appropriate support services are not in place.	Thank you for your comment and for giving us an example to illustrate your point. As 'access to advocacy' is presented as a possible way to support people at risk of less favourable treatment in the overarching principles of the guideline (1.1.2), the Guideline Committee did not feel that the point needed to be repeated here. 1.5.13 also recommends that hospital and community-based multidisciplinary teams should try and identify and address factors that could prevent a safe, timely transfer of care from hospital. Examples include homelessness and safeguarding issues.

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						This section also provides another chance to reiterate the importance of advocacy for people who may have difficulty weighing up and retaining information relating to discharge, particularly since this is a key element of the proposed service model for people with learning disabilities and/or autism and challenging behaviour.	
	SH	NHS Providers	short	13	15	General comments on the role of DISCHARGE COORDINATOR as described in the draft guidelines (relevant page and line numbers also provided in left hand columns for reference): The purpose of the discharge coordinator role is to take overall responsibility for discharge so that patients and service users and their families always know who their primary contact is for any issues or questions regarding their discharge or follow up care. Members who fed back to us agreed with the requirement to assign a discharge coordinator, but they felt that the very specific requirements in relation to which specific functions the discharge coordinator should personally carry out risked being overly prescriptive. In many cases, local teams have different but equally effective processes in place to ensure these functions are met, and take into account local circumstances and the individual needs and preferences of people and their carers on a case-by-case basis. It may be more appropriate to use the terms "a relevant health and social care practitioner" (page 16 line 17), or "an appropriately skilled	Thank you for your comment. Since 1.5.1 recommends either the creation of a discharge coordinator post *or* the appointment of a member of the hospital- or community-based team as the person responsible for the person's discharge from hospital it seems unnecessarily cumbersome to reiterate this point every time the 'discharge coordinator' is mentioned.

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						practitioner" (page 19 line 13) more widely within the document, rather than prescribing functions to the discharge co-ordinator alone. The discharge coordinator could have overall responsibility for these functions, but could delegate them as appropriate to members of hospital- or community-based teams who they consider to be best-placed to carry them out. This would allow organisations the flexibility to decide which practitioner is best placed to carry out each function on a case-by-case basis, including taking into account the preferences of service users and their families/carers, who may, for example, have existing relationships with hospital and community staff other than the discharge coordinator. Members also raised concerns that the member of staff allocated the role of discharge coordinator could find themselves overburdened with administrative tasks, which would eat into time they might otherwise spend on clinical work. This risk could be managed by assigning appropriate administrative support staff to carry out some of the functions which the guidelines currently assign to the discharge coordinator. Our members provided examples of processes in use within their organisations, which differ from those described in these guidelines and which have been evaluated as having a positive impact. We may be able to provide details on request, with our members' prior consent. See also P16 l4, p16 l5, p16 l10, p16 l12, p17 l7, p17 l18, p17 l21	

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	SH	Airedale NHS Foundation Trust	short	13	15	The use of term discharge co-ordinators implies a team of people, in reality the ward nurse is and should be the discharge co-ordinator, with the support of specialist discharge team when discharge is complex.	Thank you for your comment. The term discharge coordinator has been used in a way which is flexible throughout the guideline. Where discharge coordinator has been pluralised it has been requested in order to acknowledge that larger hospitals will require a number of people (potentially who have different roles) acting as the key person who is responsible for coordinating discharge(s).
	SH	United Kingdom Homecare Association	Short	13 -14	27-11	The word 'should' could helpfully be replaced with 'must'	Thank you for your comment. NICE guidelines only use 'must' to word recommendations which are based on specific statutory guidance and instances where not adhering to the recommendation may result in serious harm.
	SH	SeeAbility	Short	13	16	It is important the discharge coordinator is available at visiting times and can be contacted not just by phone but has an email contact too.	Thank you for your comment. We are unable to make recommendations with this level of detail without the relevant evidence to back it up. We did not find specific evidence to support this point.
	SH	NHS Providers	short	13	27	We received feedback that trusts which cover more than one CCG or local authority area, often have to accommodate different models, pathways and protocols for each commissioning body. In the worst case scenario, this could lead to patients receiving an inequitable service in relation to where they live; at best it can create confusion and inefficient use of leadership, clinical and management time, and resources. Where this is the case, the different CCGs and social care commissioners that a provider interacts with should ideally agree discharge planning protocols together. It is also helpful when NHS providers are involved in agreeing protocols in partnership with their commissioners so that they can contribute their experience and expertise, and our members would appreciate acknowledgement of this within the guidelines.	Thank you for your comment. The Guideline Committee recognises the problems you describe. In the final guideline, recommendation 1.5.3 has been changed to emphasize that it is health and social care organisations who should work together to agree clear discharge planning protocols. The Committee feels that this should help to address your point about the importance of health and social care providers and commissioners (rather than just commissioners) working together to produce protocols. We will also consider this issue as part of our implantation strategy.

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	SH	United Kingdom Homecare Association	Short	14	8-11	We consider that the discharge summary should be the responsibility of the Ward Sister and the Key Account Manager (as in item 8 above) and not placed on the junior medical staff	Thank you for your suggestion. On the basis of their experience and expertise, the Guideline Committee reached a consensus that the hospital based doctor responsible for the person's care is the most appropriate practitioner to ensure the discharge summary is sent to the GP. The evidence underpinning recommendation 1.5.6 did not provide the grounds for specifying that this should instead be the responsibility of the Ward Sister or Key Account Manager.
	SH	Action on hearing loss	Short	14	10-13	We welcome the requirement in recommendation 1.3.3 for the admitting team to "identify and address people's communication needs at the point of admission". This is consistent with the Accessible Information Standard which states that communication needs must be identified upon first contact with a service, as part of a registration or admission form. The recommendation should be reworded slightly to make it clear that the person should be offered a private room or area to make their communication needs known confidentially or an online/paper form. For example "The admitting team should proactively identify and address people's communication needs at the point admission. People should be offered a choice of how they can explain their communication needs, for example in person or on an online/paper form" When identifying communication needs, care staff should display good deaf awareness, for example speaking clearly and slowly. For people who lipread care staff should ensure the room is well it and they face the person whilst speaking, and avoid obstructing their face with hand or	Thank you for your comment. The Accessible Information Standard is now referenced in the 'communication and information sharing' section in the overarching principles of the guideline.

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						other objects.	
	SH	NHS Providers	short	14	1	This requirement may be overly prescriptive – it may not be necessary within all organisations for all practitioners to receive briefings on discharge planning protocols if they are not directly involved in discharge processes. It would be helpful if the guidelines provided flexibility for organisations to decide which staff members require regular briefings.	Thank you for your comment. The Guideline Committee did not want to change the wording of this recommendation because they wanted to capture the importance of keeping all staff (even those who are only indirectly involved with discharge processes) informed about discharge planning protocols.
	SH	Royal College of Speech and Language Therapists	Short	14	1.5.13	Whilst we welcome a discharge care plan, we are hearing from our members locally that this is difficult to implement due to the different information systems used by acute and community services as well as between health and social services.	Thank you for your comment. We have also included aspirational recommendations in this guideline about how to make information accessible across community-based and hospital-based staff, including using electronic data systems where possible (1.4.1).
	SH	Royal College of Speech and Language Therapists	Short	14	1.5.6	Any information given to the individual should be in a format that they can access and understand e.g. Aphasia Friendly.	Thank you for your comment. The Accessible Information Standard is now referenced with a direct link in 1.1.6 within the overarching principles of the guideline. The provision of communication aids to accommodate someone during their hospital stay is also given as an example of reasonable adjustment in line with the Equalities Act 2010.
	SH	Royal College of Nursing	Short	14	1.5.7	Our members commend making the Discharge Coordinator responsible for providing information & support. What areas should this cover? The patient's health? Their social care options? Both? It would be helpful to clarify	Thank you for your comment. The recommendation implies that the member of the hospital-based multidisciplinary team would provide the carer with information and support across the interface of health and social care, depending on their particular needs.
	SH	The Patients Association	short	14	1.5.9	Discharge planning: key principles of continuity of care, and decisions about future care needs should not be forced whilst the patient is in crisis. Pressures for bed spaces should never result in unplanned/uncoordinated discharge.	Thank you for your comments. We have covered both of these points in 1.5.9, 1.5.11 and 1.6.2.
	SH	Action on	Short	14	3	A bullet should be added to 1.3.1 to include	Thank you for your comment. All bullets have been removed

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		hearing loss				sharing of 'any equipment or aids, such as hearing aids, glasses or mobility aids, that the person needs, and how to use and maintain them'. Equipment and aids, and knowledge of how to use and maintain them, are often lost when people move from one setting to another.	from this recommendation. However, recommendation 1.1.6 now links directly to NHS England's Accessible Information Standard as part of the 'communication and information sharing' section of the overarching principles of the guideline. Recommendation 1.3.6 also gives the example of providing communication aids as a reasonable adjustment that could be made by the admitting team to accommodate the person in hospital.
	SH	NHS Providers	short	14	4	Sharing assessments and updates across hospital and community-based teams may also be challenging given current issues with systems integration and interoperability (please see comment number 13 above).	Thank you for your comment. This recommendation was derived from the best available evidence alongside Guideline Committee consensus. The Guideline Committee understand that this may only happen in some place within UK practice; however, it is intended to be aspirational.
	SH	Sense	Short	14	6	As per comment 1, insert the following addition to the point: including medicines data *and information and communication needs*	Thank you for your comment. Recommendation 1.1.6 now links directly to NHS England's Accessible Information Standard as part of the 'communication and information sharing' section of the overarching principles of the guideline. Recommendation 1.3.6 also gives the example of providing communication aids as a reasonable adjustment that could be made by the admitting team to accommodate the person in hospital.
	SH	NHS Providers	short	14	8	This requirement is aspirational. In practice, it is not currently the norm for GPs to receive discharge summaries within 24 hours. Our members are working towards this, but the guidelines could helpfully allow a margin of error.	Thank you for your comment. The Guideline Committee made the recommendation because it felt strongly – from the evidence and their own experience – that this *should* be normal practice. The recommendation is intended to be aspirational (this is not statutory guidance).
	SH	Guild of Healthcare Pharmacists	Short	14	8	The term 'Doctor' needs to be reworded to allow for nurse-led units. We are aware of a local hospital Trust that has pharmacists being largely responsible for medicines lists so this we believe should be reflected in wording, perhaps encouraging skill mix in contributing to the content of discharge summaries. The 24 hours target stated should probably specify 'electronic discharge summary' as this is	Thank you for your comment. The Guideline Committee felt it was unnecessary to change the wording of this recommendation. We accept local variation and we anticipate the people will understand the intention of the recommendation and be able to apply it to their own setting.

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						the only practicable way to achieve this target. It may be worth exploring a recommendation for community pharmacy to access discharge summaries directly in order to address miscommunication and medicine supply issues. However, there would obviously be huge information governance implications.	
	SH	Derbyshire County Council	Short	14	9	says the summary should be sent to the GP within 24hrs of discharge – it is worth having a line about someone ensuring the system used to send these works in real time to ensure no delay to healthcare post discharge?	Thank you for your comment. The evidence from which this recommendation was developed did not stipulate the specific media which should be used when sending the discharge summary the GP. Therefore it is not possible to add in the level of detail you are suggesting.
	SH	Royal Pharmaceutical Society	Short	14	11	If changes have been made to a patient's medicine they should be referred to the community pharmacist for a professional handover and continued support on their medicines use. This may include a discharge medicines use review or a new medicines service.	Thank you for your comment. We have included community pharmacist in the definition of 'community based multidisciplinary team' which appears in the glossary. As such, they should be involved in a person's discharge (if necessary).
	SH	Macmillan Cancer Support	short	14	12	As highlighted above, identification of carers is a challenge.	Thank you for your comment. We acknowledge the difficulty that some people have with defining themselves as a carer. We have added the following definition to the 'terms used in this guideline' section: "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." We also hope that the changes in the Care Act 2014, including the right to caregiver's assessment, will help people to identify their rights when fulfilling this challenging role more readily.
	SH	NHS Providers	short	14	12	This requirement does not provide sufficient flexibility for providers to work to local and individual needs on a case-by-case basis. For	Thank you for your suggestion. The evidence underpinning this recommendation came from the carer support review area and emphasized that families and carers should be given

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						example, carers may prefer to receive this support from a community-based practitioner if that is their usual point of contact, or they may not be able to attend the hospital at a given time to meet with a hospital-based practitioner. The guidelines could use less prescriptive wording, for example "make a health or social care practitioner involved in the person's care responsible".	information during discharge planning. The Guideline Committee concurred with the evidence that found that although written information could be useful, face to face contact with practitioners is preferable. On the basis of their expertise and experience, the Guideline Committee reached a consensus that in order to ensure continuity in support during the hospital stay, it would be most appropriate for a member of the hospital based multi-disciplinary team to provide that information and support.
	SH	Age UK	Short	14	18	Additional entry: Where there is not a carer, make sure sufficient provision is in place to support their transition home This may include engaging with local voluntary and community sector providers.	Thank you for your comment. Recommendation 1.5.17 encourages discharge coordinators to identify people from the voluntary sector who will be able to provide support once the person is discharged.
	SH	SeeAbility	Short	14	19	We query the emphasis only on providing out of hours information to those who need end of life care. There are going to be individuals, families and supporters of people who have complex medication regimes and equipment that have been introduced in hospital that will need support in the 24 hours once discharged, not just those in a terminal phase. This is especially the case as discharge often itself happens out of hours, ie people arriving home in the evening or nightime.	Thank you for your comment. The Guideline Committee agreed with your feedback and have added a new recommendation (1.5.9) for people with complex needs to reflect this: "The discharge coordinator should consider providing people with complex needs and their families with details of who to contact about medicine and equipment problems that occur in the 24 hrs after discharge."
	SH	Age UK	Short	14	22	Add an additional sentence: The person and carer should have a clear understanding of where to go for longer-term support, including in a crisis, beyond this 24 hour period.	Thank you for your comment. Evidence provided by an expert witness, Claire Henry, and supported by the Guideline Committee informed 1.5.8, which recommends that for people with end of life care needs, it is especially important that problems with equipment and medicines are rectified very quickly. To this end the Guideline Committee agreed there should be a named individual (whether hospital or community based) who can respond to problems occurring within 24 hours of discharge. The Guideline Committee did not feel that they had the appropriate evidence to add a recommendation on

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							longer-term support for this population.
	SH	Age UK	Short	14	24	In this paragraph under principles, people should expect that dementia and any cognitive health risk, including delirium, should have been assessed and recorded to support the discharge process. We cannot have confidence this is happening consistently (see point 6 above on the National Audit of Dementia). Also consider findings from the audit that only 19 per cent of case notes had evidence that the patient's level of cognitive impairment, using a standardised assessment, had been summarised and recorded at the point of discharge.	Thank you for your comment. This is largely covered by the recommendations on Comprehensive Geriatric Assessment (1.3.10).
	SH	Royal College of Surgeons	Short	15	18-28	Awareness that this can be a very stressful time for patients and families. Carers UK's State of Caring Survey (http://www.carersuk.org/for-professionals/policy/policy-library/the-state-of-caring-2013) in 2013 showed that those most likely to be re-admitted to hospital were those where families and carers were not involved in decisions or there was no social support	Thank you for your comment. The report you mention was not retrieved in the searches because it is not indexed in databases as specifically relating to admission/ discharge / transfer of care. However, involving families and carers in discussions about care (where consent is given) is an overarching principle of the guideline. There are sections of the guideline called 'Involving carers' and 'Support and training for carers'. The guideline reiterates that families' and carers' willingness to provide support, circumstances and relationship to the person should all be considerations when writing a discharge plan. There are specific recommendations on training carers and the practical and emotional aspects of providing care.
	SH	United Kingdom Homecare Association	Short	15	18-28	We are not convinced that the list included in this item would have any material or beneficial impact on someone's emotional wellbeing upon discharge**:** the two issues, the narrative and the list, seem unrelated	Thank you for your comment. In keeping with the overarching principles of the guideline the recommendations strive to view the person holistically. The distinction between a person's social and emotional well-being and the practicalities of their daily life are arguably interlinked.
	SH	Action on hearing loss	Short	15	15-23	In 1.3.6, an example should be added on reasonable adjustments for the large numbers of people with hearing loss in these settings: "People with hearing loss have their hearing aids	Thank you for your comment. The Nursing toolkit would not have been retrieved for our evidence review as it is not empirical evidence. The provision of communication aids is now given as an

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						and any other equipment with them, and assistive equipment such as hearing loop is made available to help them communicate. Communication support such as qualified, registered BSL interpreters must be made available for people who are deaf who use BSL". For more information on what hospitals can do to make their services accessible for people with hearing loss, please see our 'caring for older people with hearing loss' nursing practice toolkit http://www.actiononhearingloss.org.uk/supporting-you/gp-support/nursing-toolkit.aspx	example of a reasonable adjustment that should be made to accommodate someone in hospital. This is in line with the Equalities Act 2010.
	SH	Derbyshire County Council	Short	15	1-3	this is great, can we add 'wherever possible a person should return home first'?	Thank you for your comment. The Guideline Committee did not feel it was appropriate to add this on account of the fact that they did not have any evidence available (which met the inclusion criteria) to qualify doing so.
	SH	NHS Providers	short	15	1	While our members would always explore every opportunity to ensure people do not have to make decisions about long term care while they are in crisis, in practice, requiring this in the guidance could lead to delays in people being discharged. Where intermediate or step down care are not available at the time an individual is medically fit to be discharged, the choice may be between remaining in hospital or making a longer term decision. The guidelines could perhaps require that people are not pressured to make such decisions, and receive appropriate support where they need to make decisions about their longer term care.	Thank you for your comment. The Guideline Committee did not feel it was appropriate to change this recommendation.
	SH	Airedale NHS Foundation Trust	short	15	1	This organisation would support the statement around not expecting a patient to make decisions about long term care when in crisis, however when there is pressure on beds and capacity issues this is very difficult. The discharge to assess approach would support	Thank you for your comment. The model of transfer from hospital, known as 'discharge to assess', which has been initiated in various UK locations, was identified as a major gap in the review evidence. The Guideline Committee could not make practice recommendations about this new and evolving model because

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						this recommendation and perhaps implementing discharge to assess model should be part of the recommendations.	to date, no research evidence has been published which meets the criteria for inclusion in the review and presentation of evidence. However, having identified a gap in the evidence the Guideline Committee agreed to research recommendation for "Assessment at home to improve hospital discharge success rates" (see section 5 of Recommendations for Research).
	SH	Foundations	Short	15	1	- The primary aim of the North Somerset Intermediate Care Service is to ensure that people are not making long term housing decisions at a point of crisis. The Service is offered to people who are leaving hospital and returning home, leaving a residential or nursing home to return home or at risk of being admitted unnecessarily to hospital or residential/nursing care, to support them stay at home. The project allows people to consider their housing future during the 6 week re-ablement period whilst they are cared for in the Intermediate Care Unit. Results have shown that a considered choice will save resources as the majority choose to return home rather than go into residential care. The Local Authority saved £1.4m in the first 6 months of the scheme through avoiding residential care costs. 15% of those completing Enablement during Feb 2012 to January 2012 returned to their own home following Enablement who before the new pathway was put into place would have remained permanently in nursing or residential care. The 6 week period allows for their home to be properly assessed and adapted to ensure their continued independence using the expertise of Home Improvement Agency support to	Thank you for your comment and for sharing the outcomes of your re-ablement initiative. Step-down/ intermediary facilities which are not part of an admission or discharge process are beyond the remit of this guideline. However please note that a NICE social care guideline on Intermediate care – including reablement is currently in the process of development.

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						project manage any necessary work.	
	SH	City of York Council Adult Social Services	Short	15	1.5.10	**'People should not have to make decisions about long term placements whilst they are in crisis'** - We support this as one of the key principles with regard to transition planning, and there needs to be the resource to make this happen – e.g. transitional placements for residential and nursing care; opportunities for extended convalescence and rehabilitation; there needs to be a joint health and social care approach to this issue.	Thank you for your support. Step-down/ intermediary facilities which are not part of an admission or discharge process are beyond the remit of this guideline. However please note that a NICE social care guideline on Intermediate care – including reablement is currently in the process of development.
	SH	Royal College of Nursing	Short	15	1.5.10	Our members commend that people would not have to make decisions while in hospital. Are statements required about the stock and capacity of intermediate and step down facilities required? Also do these services always cater well for all patient groups?	Thank you for your comment and support of this recommendation. Unfortunately it is not within the scope of NICE social care guidelines to make recommendations about the design or capacity of the local care and support market.
	SH	City of York Council Adult Social Services	Short	15	1.5.11	**'Hospital managers should try to ensure that any perceived or real pressures to make beds available do not result in unplanned and uncoordinated hospital discharges' -** we very much support this recommendation but it is a real challenge when hospitals and Ward staff are under extreme pressure, as many of them were during the last winter – our experience is that ward staff are under extreme pressure and this can lead to patients being put under pressure to make decisions at a time when they are least able to do so. One concern raised is that ward staff are under so much pressure that person-centred approaches may be sacrificed for discharge the person from hospital. One alternative is to have some facilities where people with complex needs can move to (with both health and social care support provided), to	Thank you for your comment. We acknowledge the challenging context within which this guideline has been developed and the pressures within the system within which it will be implemented. UK-based evidence on staff training to achieve successful transfers from hospital to home or the community was identified as one of the biggest gaps in evidence within the evidence review. A recommendation for research was made in this area and the Guideline Committee agrees that this will help address some of the issues you identify about inappropriate referrals and a lack of person centred approaches to assessment for discharge. In the meantime, the training recommendation (1.7.1) states that all relevant staff should be trained in the hospital discharge process and that this training should be updated. We will also address these pressures and resource issues in our implementation work on this guideline.

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						give them time to make informed and considered decisions about their ongoing care and support requirements without extreme pressure to quickly make decisions and move on. One problem we have is receiving the 'right' referrals at the 'right time' for people in hospital – if ward staff are routinely referring people who don't actually need SW input this can take up limited social work time on referrals that are not relevant – training needed for ward staff regarding who to refer and when.	
	SH	Stockton-on-Tees Borough Council	Short	15	1.5.12	We are not sure if 'appropriateness of accommodation' would be considered under 'Safeguarding', if not can we suggest it is added to the bullet point list. Should returning accommodation not be an appropriate option, then early contact needs to be made with the Local Authority Housing Service to determine what other housing options may exist (should for example an adaptation may not be a viable option).	Thank you for your comment. These are just examples so the Guideline Committee did not feel it was appropriate to add this bullet point. 'For example' was added to this recommendation to highlight this.
	SH	The Patients Association	short	15	1.5.12	Discharge planning: all plans from care plans, advanced care plans and communication passports must inform the discharge plan. However, this means that all these plans must be recorded, using standardised templates.	Thank you for your comment. Recommendations about recording individual preferences, medication, care plans and making this information accessible to all community- and hospital-based staff are reiterated throughout the guideline. The Guideline Committee did not want to be too prescriptive about the form these documents should take (i.e use of templates e.t.c).
	SH	Royal College of Speech and Language Therapist	Short	15	1.5.14	The RCSLT recommends adding any specific communication needs to (as outlined in Mental Capacity Act)	Thank you for your comment. Communication needs will be included in the care plan, and the discharge plan - as ongoing support needs. Recommendation 1.1.6 now links directly to NHS England's Accessible Information Standard as part of the 'communication and information sharing' section of the overarching principles of the guideline. Recommendation 1.3.6 also gives the example of providing communication aids as a

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		s					reasonable adjustment that could be made by the admitting team to accommodate the person in hospital.
	SH	Royal College of Nursing	Short	15	1.5.14	Should include the person's wishes and who holds lasting power of attorney.	Thank you for your comment. The person's wishes are included throughout the guideline; person-centred care is an overarching principle. The Mental Capacity Act is also referenced within the overarching principles – to refer to if there is any doubt about the person's capacity to consent.
	SH	SeeAbility	Short	15	8	In considering factors that may impact on discharge, it may be useful to see listed: • provision of equipment • revising support packages/funding to meet changed needs • time to secure/train staff to meet changed needs • ability of family and informal carers to sustain support • funding disputes between health and social care	Thank you for your comment and providing further examples of potential factors that may impact on discharge. We have covered factors that may lead to delayed discharges in more detail in the context section of the guideline. However, the list of example in 1.5.12 is not intended to be exhaustive.
	SH	Foundations	Short	15	8	Hospital based staff will need to include the safety and appropriateness of the patients home within the discharge plan if it is to be effective. The home will need to be checked to ensure that practical issues such as heating, access to facilities, sleeping arrangements, equipment such as grabrails, shower seats are organised promptly prior to discharge. Many Home Improvement Agencies (HIAs) manage 'home from hospital' schemes that take on this role coordinating and organising practical measures to help fulfil the discharge plan. They organise practical measures such as keysafe installation, moving a bed downstairs, fitting grab-rails, checking heating etc. HIAs can take	Thank you for your comment. The Guideline Committee recognise the potential need for adjustments in the home, alongside health and social care assessments more broadly, to ensure timely and effective transfer of care. 1.5.18 recommends that the discharge coordinator should discuss the need for any specialist equipment and that this equipment should be in place at the point of discharge. There is also an extra bullet on 1.5.13 also references: • the need for assessments for eligibility for health and social care funding as a factor that could prevent the safe and timely transfer of care.

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						on responsibility for this part of the discharge plan ensuring the work is carried out and coordinating more long term measures such as stairlift/level access showers. Also line 18	
	SH	Sense	Short	15	15	Add to 1.5.13 a reference to ensuring that social services carry out an assessment of care and support needs in line with the Care Act at an appropriate point before discharge.	Thank you for your comment. Recommendation 1.5.13 now has an extra bullet: • the need for assessments for eligibility for health and social care funding The Care Act is a central point of reference throughout the guideline.
	SH	Age UK	Short	15	17	Add at the end of sentence: including individual goals for care.	Thank you for your suggestion. As person-centred care is an overarching principle of the guideline it was not deemed necessary to amend this recommendation.
	SH	Macmillan Cancer Support	short	15	18	The scope and workload of a discharge coordinator represents a challenge, given the numbers of admissions and discharges into and out of hospital, and the need to have an overview of health social care and third sector service provision locally.	Thank you for your comment. The Guideline Committee recognise the challenging nature of the discharge coordinator role. The recommendations are based on the best available evidence alongside Guideline Committee consensus. They are intended to be aspirational. We will also consider these issues as part of our implementation work.
	SH	Guild of Healthcare Pharmacists	Short	15	22	We suggest that the term 'medicines optimisation' is used rather than 'medicines management'. The latter term is a part of the wider medicines optimisation agenda which is a patient-focused approach to getting the best from investment in and use of medicines that requires a holistic approach. Most importantly medicines optimisation differs from medicines management in that it focuses on outcomes and patients rather than process and systems.	Thank you for your suggestion. The recommendation has now been changed from 'medicines management' to 'information about the person's medicines'. The guideline also cross references NICE's guideline on medicines optimisation, and this is a term which appears in the glossary.
	SH	Action on hearing loss	Short	16	25-29	Recommendation 1.4.1 should be reworded to include communication needs in items that should be recorded on the electronic data	Thank you for your comment. The Accessible Information Standard has now been referenced with a direct link (1.1.6) in the overarching principles of the guideline.

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						system. For example "record multidisciplinary assessments, prescribed medicines, individual preferences, and communication needs in an electronic data system". This would bring the recommendation in line with the Accessible Information Standard which states that communication needs must be recorded on electronic data systems. The recommendation should also make reference to the standard's requirements for sharing information. For example "make it accessible to both hospital and community based multidisciplinary teams, subject to information governance protocols and the Accessible Information Standard". The standard states that communication needs must be included in existing data sharing processes between health and social care organisations.	
	SH	Royal College of Surgeons	Short	16	1-4	Also clear information on who to contact with queries about condition post discharge. It is not just social care follow up they need.	Thank you for your comment. The Guideline Committee agrees with your point and believes this is reflected in recommendation 1.5.17 of the final guideline. This recommendation states that the discharge coordinator should identify practitioners from primary and community health (as well as social care, housing and the voluntary sector) who will provide support after the person is discharged. The details of those practitioners should be recorded on the care plan, which the person will receive. They will therefore know which primary and community health practitioner to contact about their condition after they have been discharged.
	SH	United Kingdom Homecare Association	Short	16	9-11	The process of the Discharge Coordinator and the community care team agreeing a plan for ongoing treatment or care is to what end? Why does there have to be agreement? The important factor is that there is a plan and we are not convinced that an institutional based	Thank you for your comment. Please be assured this is not the intended meaning of the recommendation. There is no hierarchy inferred within this arrangement.

Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its officers or advisory committees

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						Discharge Coordinator should have inferred rights of veto over community plans	
	SH	Crisis	Short	16	1.5.13	This is vitally important. As a recent Health Watch report[8] found that not being involved in discharge planning can have significant impact on a patient's health and wellbeing. The report specifically looked at the experience of homeless people in hospital and they found that when homeless people were in hospital they were not involved in decisions about their treatment or discharge. Many believed that this was due to stigma and discrimination. We therefore strongly support this section of the draft guidelines.	Thank you for your supportive comment.
	SH	Royal College of Nursing	Short	16	1.5.16	There should be a named individual who coordinates this and should be the most appropriate professional	Thank you for your comment. As stipulated in the recommendations the discharge coordinator would be the name individual, and this person would be the most appropriate professional according to the person's needs.
	SH	Royal College of Nursing	Short	16	1.5.16	This must include all individuals with cognitive problems.	Thank you for your comment. This recommendation covers all groups – including people with cognitive problems.
	SH	Royal College of Nursing	Short	16	1.5.17	This section talks about the discharge assessment, our members consider that the district nurse should also be involved in the assessment particularly if the patient is known or should be known to the District Nursing Team.	Thank you for your comment.
	SH	Stockton-on-Tees Borough Council	Short	16	1.5.18	Whilst this is welcomed, we need to indicate that we are seeing a growing demand for adaptations (which is often out-stripping resources available), resulting in long waiting lists/times. At the present time Stockton-on-Tees BC is operating an equipment loan	Thank you for your comment and your support for this recommendation. We recognise the current issues arising from budget pressures in the public sector; our recommendations attempt to inform best practice under the current conditions.

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[8] Healthwatch (2015) Safely home: what happens when people leave hospital and care setting?

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						scheme (stair lifts and ramps) to support hospital discharge (rather than an applicant having to make a formal Disabled Facilities Grant application), however this scheme is funded by Stockton-on-Tees BC resources (as they are not eligible for Disabled Facilities Grant funding). The value of the Stockton-on-Tees BC top-up funding for this scheme has decreased in recent years and is likely to cease due to budget pressures across the public sector.	
	SH	Royal College of Nursing	Short	16	1.5.20	This should identify any safeguarding issues.	Thank you for your comment. The need to identify safeguarding issues that may prevent a safe or timely transfer of care as early as possible is referenced in 1.5.13.
	SH	Alzheimer's Society	Short	16	5	This recommendation should include reference to practitioners from the third sector who, in many local areas, provide post-discharge support services commissioned by the NHS or provided on a voluntary basis.	Thank you for your suggestion. The voluntary sector has been added to this recommendation, and it is also defined in the glossary as: "Not for profit organisations that are independent of the government and local councils. Includes third sector and 'civil society' organisations."
	SH	Foundations	Short	16	5	Foundations welcome this section and the inclusion and consideration of housing in every clause. It should be recognised that more long term measures such as housing adaptations will need to be owned by a single agency such as an HIA to ensure the work is carried out in a timely and effective manner for both self-funders and those in receipt of statutory grants	Thank you for your support. Unfortunately it is not within the scope of NICE social care guidelines to make recommendations about the design or capacity of the local care and support market.
	SH	Marie Curie	Short	16 -17	25-9	(1.5.21-24) Rapid and effective coordination between health and social care are crucial to this being successful. The draft guidelines make no reference to NHS Continuing Healthcare, which should be an important mechanism for this. People who are approaching the end of their life are often delayed in their discharge from hospital whilst funding is agreed for the	Thank you for your comment. In light of yours and other stakeholder comments, the Guideline Committee discussed the issue of delays caused by waiting for assessments for funding eligibility and were in agreement about the need to include it. The Guideline Committee reached a consensus that 'assessments for health and social care eligibility' should be added to the list of factors that might prevent a safe, timely discharge from hospital (1.5.13). They also added 'how to

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						package of care needed to support them to return home. Timely access to NHS Continuing Healthcare via the Fast Track Tool or effective use of the Decision Support Tool can be crucial to achieving a successful transition; however, this is not always achieved. It would be helpful if good practice in awarding Continuing Healthcare or alternative packages of care was encouraged in these guidelines, in line with sections 97-107 and 167-171 of the Department of Health's 'National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care' (Revised 2012).	arrange assessments for eligibility for health and social care' to the list of areas related to hospital discharge in which staff are trained (1.7.1).
	SH	United Kingdom Homecare Association	Short	16 -18	26-9	End of life and/or palliation should include counselling for the whole and extended family concerning the continuation of family life after death**:** the positive role of the dying person in the family should be reinforced particularly if they are the parent of younger children, but in any case adaptation of family life to the dying process and subsequent loss should form an integral part of the transition planning PTO	Thank you for your comment. Unfortunately we are only able to make recommendations based on the evidence which met our inclusion criteria. The evidence from which these recommendations were derived did not extend to this level of detail. The focus of the guideline was specifically on the transitions between hospital and home. You may want to refer to the forthcoming NICE guidance on Care of the dying adult, which is more likely to cover the emotional needs of the family with regards to the positive role of the dying person.
	SH	Airedale NHS Foundation Trust	short	16	25	In relation to end of life care, this organisation has implemented the Gold Line, a service delivered using the telemedicine link for patients identified to be in the last 12 months of life. Benefits to patients is being demonstrated.	Thank you for your comment and for sharing information about your Gold Line initiative. Unfortunately telemedicine was outside the remit of our scope for this guideline.
	SH	Stroke Association	Short	16	25	We are pleased that the guidelines recognise the importance of making general and specialist palliative care services available for people who have end-of-life care needs. The National Clinical Guidelines for Stroke and National Stroke Strategy recommend that all stroke patients should have access to specialist	Thank you for your support. The Guideline Committee made recommendations for research based on the largest Thank you for your response.identifiable gaps in the evidence based on our specific review questions. Our question on end-of-life care was not condition-specific but rather referred to anyone with social care and end-of-life care needs transitioning between hospital and home. The issue of unmet end-of-life care

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						palliative care expertise and that staff providing this care receive appropriate training. The most recent SSNAP data (January – March 2015) shows that only a small minority of patients with un-survivable stroke are currently being supported to die at home even though the National Audit Office (2008) states that 'most people wish to be cared for and die in their home'. We need more research on why stroke patients do not get support to make choices about end of life care.	preferences is a much bigger issues and beyond the remit of this guideline. You may be wish to refer to NICE's forthcoming guideline on Care of the dying adult.
	SH	Macmillan Cancer Support	short	16	26	The Choice Review showed need for greater joint working between palliative care specialists and other clinical staff, and between secondary care and primary care staff, to identify people who may need end of life care as early as possible. People said that: they wanted organisations to have shared access to information, a single number to contact and support staff (care coordinators) to help them "navigate" the system; they felt that having a named professional responsible for their care at the end of life would improve coordination and ensure preferences are met; and bereaved carers reported in the 2013 VOICES-SF survey that the planning and coordination of care was often extremely poor; less than half (42%) of respondents thought that community services were "definitely" well coordinated and less than a third (31%) thought that hospital services "definitely" worked well together with GP and other services outside hospital. To further the link between the individual and those delivering their care, respondents to the National Choice Review highlighted the high	Thank you for your comment. The review of research on transitions between hospital and home for people with end of life care needs did not specifically identify evidence to support a distinct care coordinator role for people with end of life care needs. However, the Guideline Committee reviewed evidence of the benefits of having a single individual coordinating people's discharge from hospital. The Committee was therefore unanimous in their support for appointing a discharge coordinator for all adults with social care needs, although they decided against stipulating exactly how hospitals should allocate the role. The Guideline Committee believes that recommending a discharge coordinator and assigning specific responsibilities to them should address many of the issues around end of life care transitions that were reported in the Choice Review.

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						quality service given by individuals acting as a single point of contact for the person and those important to them regarding issues with the services and treatments required. These 'care coordinators' were seen as invaluable in either navigating the health and care system on behalf of people or offering advice on services. The Review advised the option of a 'care coordinator' be offered to everyone with end of life care needs. This role could be fulfilled by either a care or health professional, or a family member, friend or carer, but it should be an individual with authority and expertise who can deliver results for the individual. There should also be explicit arrangements for cover for this role in times of absence.	
	SH	Alzheimer's Society	Short	16	26	People with dementia are in many cases not recognised as having palliative care needs in the same way as people with other long-term conditions. Improving identification of people with dementia's palliative care needs is vital for commissioners to be able to make adequate palliative care services available.	Thank you for your comment. We agree that this is an important issue but no evidence was located specifically about the palliative care needs of people with dementia during transition between hospital and home. However, please see NICE Clinical Guideline 42 Dementia: supporting people with dementia and their carers in health and social care. There is a specific section in the guideline with recommendations about palliative care for people with dementia.
	SH	Stroke Association	Short	17	10-16	Early supported Discharge (ESD). There should be stroke specialist ESD for all people discharged from hospital after a stroke. But we know from the Royal College of Physicians Sentinel Stroke National Audit Programme (SSNAP) 2015 that this is not happening consistently. 'There is randomised trial based evidence of the benefits of stroke specialist ESD which has informed (this) widespread service development. The trial that was performed comparing in-patient stroke unit care with a generic domiciliary	Thank you for your comment. In line with your suggestion 1.4.5 recommends that people admitted to hospital after a stroke should be treated in a stroke unit and be offered early supported discharge. This stroke-specific recommendation also cross references NICE's guideline on stroke rehabilitation. We acknowledge that this may not always be happening consistently in practice, but the recommendation is aspirational and based on the best available evidence.

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						team showed worse outcomes in patients managed at home. ESD should therefore be considered a specialist stroke service and consist of the same intensity and skill mix as available in hospital, without delay in delivery. There are 16 non-stroke specific ESD services currently being commissioned - they cannot be assumed to be equivalent.'	
	SH	City of York Council Adult Social Services	Short	17	1.5.25	**'Early supported discharge' –** we support this concept in principle but it needs more work to understand what this will mean in practice and also how community services provided by health can be resourced adequately to support this.	Thank you for your comment. As part of our implementation support we aim to highlight other resources that can help as well as encouraging submission of practice examples for shared learning - eg.where local systems have successfully implemented early support discharge services.
	SH	Crisis	Short	17	1.5.27	We fully agree with this but recent mystery shopping research[9] carried out by Crisis into the experiences of single homeless people found that local authorities were frequently failing to provide single homeless people with meaningful advice and assistance and many were not given the opportunity to make a homeless application to see if they qualified for an offer of settled accommodation. In 37 out of the 87 visits, local authorities made arrangements to accommodate mystery shoppers that evening, either through the provision of emergency accommodation or because they had negotiated for them to return to their previous address. In the remaining 50 visits, most of which were at London boroughs, they received inadequate or insufficient help. It was common for mystery shoppers to simply be signposted to written information about renting	Thank you for your comment and for highlighting current concerns with this issue in practice. In light of yours and other stakeholders' comments the Guideline Committee agreed that the guideline should be clearer about the important role of the voluntary sector and we have therefore made a number of changes to the final document. We have amended the description of the hospital and community-based multidisciplinary teams to reflect that they should include voluntary sector practitioners and we have added 'voluntary sector services' to the list of services that should be made available to support people following discharge from hospital.

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[9] Crisis (2014) Turned Away

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						privately or even turned away without any help or the opportunity to speak to a Housing Adviser. This was despite the fact that the mystery shoppers were playing a number of extremely vulnerable characters including someone fleeing domestic violence and someone with learning difficulties. In a significant number of visits (29) mystery shoppers did not receive an assessment and were not given the opportunity to make a homelessness application. The mystery shopping research also found that people were often being refused any type of help until they supplied both proof of identification and/ or their homelessness. This happened across all local authorities, although it was a lot more common in London, where five out of seven boroughs visited consistently turned people away despite the fact that none of the characters played by the mystery shoppers had a place to stay that night. As it currently stands the homelessness legislation gives local authorities a significant amount of discretion when assessing whether someone is vulnerable enough to qualify as priority need. The Supreme Court handed judgment on 13th May 2015 in three joined appeals - Hotak v London Borough of Southwark; Kanu v London Borough of Southwark; Johnson v Solihull Metropolitan Borough Council [2015] UKSC 30 – ruled that the test of vulnerability should no longer be in comparison to someone who is already actually homeless, but to the ordinary person facing homelessness. This ruling means that a larger	

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						number of single homeless people will now be considered priority need and owed the main homelessness duty. **It should also be noted that many single homeless people will have social care needs which are hidden**; or have not been formally identified by social care professionals prior to admission. Any assessment to inform discharge planning undertaken on the wards should specifically consider the presence of social care needs; for many homeless people, especially rough sleepers, admission to hospital offers a key opportunity for a full assessment of needs. Voluntary organisations will be providing social care support to them in an unofficial capacity. Some will be on the cusp and if left to live by themselves would need social care support that the voluntary organisation would have been providing. Therefore some might be admitted into hospital and not have known social care needs but they should assessed especially if they have been receiving support from a voluntary organisation. We would recommend that hospitals make links with voluntary organisations who can advocate on behalf of the patient if necessary to ensure that the Local Authority gives them the help with housing the need. Research[10] has shown that having a pathway like model within the Hospital is best as the workload and complexity of	

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[10] http://www.pathway.org.uk/publications/pathway-research-and-service-development-publications/

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						housing is too great for medical professionals alone to advocate on behalf of homeless people. They should be involved in the process in collaboration with a voluntary organisation who may have greater housing expertise. Having a dedicated person to advocate on their behalf works best.	
	SH	Royal College of Nursing	Short	17	1.5.27	This section talks about plans just before the patients are discharged, our members feel that the timelines seem quite vague. It would be helpful to be explicit that discharge planning starts on the day of admission.	Thank you for your comment. While there is no specified time reference in recommendation 1.5.27 the intention is not that this happens 'just before discharge'. The 'discharge planning' section of the guideline explicitly states that planning for discharge should start from the point of admission, or earlier if possible. For example 1.5.13 recommends that hospital- and community-based multidisciplinary teams should work together to identify and address factors which could prevent a timely, safe transfer of care.
	SH	Royal College of Nursing	Short	17	1.5.27	Readmission – Our members wondered if the discharge coordinators should prioritise people with learning disabilities? Some data indicates that people with learning disabilities are more at risk of readmission and repeated admission – see www.ekhuft.nhs.uk/ldra [MARINA AS LOCA DATA IS MENTIONED HERE, DOES IT REFLECT NATIONAL TREND?]	Thank you for your comment. The Repeated Admissions Care Pathway would not have been retrieved as part of the evidence review as it is not empirical evidence. The evidence from which this recommendation was derived was about older people. However, the Guideline Committee felt that the findings could be extrapolated to people with complex needs, referred here to 'people at risk of hospital readmission'. This description would include people with learning disabilities.
	SH	Stockton-on-Tees Borough Council	Short	17	1.5.28	This point references the need for 'suitable temporary accommodation' for homeless people. To ensure this can happen this needs to highlighted as early as possible with the Local Authority Homelessness Service (link back to point 11 below) as often this accommodation is very generic and may not be suitable should specialist accommodation (and/or support) be required.	Thank you for your comment. The specific recommendation you are referring to has now been deleted. However, in line with the Care Act 2014 the guideline regards housing as a central aspect of health and well-being related provision and this is reflected in several recommendations. For example, 1.5.13 cites homelessness as the first example of a factor which would prevent the safe and timely transfer of care from hospital.

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	SH	Macmillan Cancer Support	short	17	4	The Midhurst Macmillan Service http://www.macmillan.org.uk/Aboutus/Healthandsocialcareprofessionals/Macmillansprogrammesandservices/Specialist-care-at-home.aspx provides active specialist palliative care through a range of interventions undertaken either at home or in the community. It consists of specialist professionals as well as a large team of volunteers providing proactive specialist palliative care and support following early referral from either the hospital or GP; and works with members of primary healthcare teams, community services, social services, care agencies and voluntary organisations within the area. A formal economic evaluation showed **the biggest contributors to its success has been early referral**; breadth of services delivered at home; and role flexibility. The Service works with flexible community based teams and has been able to maximise patient choice by providing as much treatment and support in the home or community as possible. So for the patient that means: less frequent A&E attendances; fewer nights in hospital; and dying in their preferred place. The range of clinical interventions on offer and ability for support staff to work across boundaries, not only help avoid the need for travel or admission to hospital or hospice, they also provide the opportunity to develop a relationship of trust between the patient, carers, family members and the team.	Thank you for your comment. The Midhurst Macmillan service provides an excellent example of the kind of multi professional palliative care team cited in recommendation 1.5.23. Although there were some limitations in the evidence they reviewed, the Guideline Committee agreed that where appropriate, specialist palliative services should be made available. The outcomes of the service you describe seem to support the evidence on which recommendation 1.5.23 is based.
	SH	Macmillan Cancer Support	short	17	7	Greater emphasis here about the need for staff, including the discharge coordinator, to act at pace for people at the end of their life to ensure expressed place of care or death is achieved as	Thank you for your comment. The Guideline Committee felt confident that the wording of this recommendation implied that there was a requirement for practitioners to act quickly if people who have end-of-life needs are to die in their preferred

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						much as possible.	place.
	SH	Age UK	Short	17	9	Additional paragraph: All health and social care practitioners should have sufficient training to engage people in sensitive discussions about end of life care.	Thank you for your comment. In light of your suggestion the following bullet point has been added to 1.7.1: • how to have sensitive discussions with people about end-of-life care.
	SH	Airedale NHS Foundation Trust	short	17	17	Approach to readmissions, this Organisation has implemented the use of the LACE tool, the initiative was in response to a CQUINN measure last year and the practice has continued.	Thank you for your comment. The evidence reviewed by the Guideline Committee did not provide the grounds for recommending specific tools to assess risk of readmission. However, the example you provide will be considered for our work to support the implementation of this guideline.
	SH	Airedale NHS Foundation Trust	short	17	24	The arrangements for homeless is very challenging, particularly around vulnerable elderly people who become the status of homeless when the care setting that is their home declines to have them back due to increased care needs.	Thank you for your comment. We acknowledge the challenging nature of discharge for people who are homeless or who will become so due to changes in circumstances. The specific recommendation you are referring to has now been deleted. However, in line with the Care Act 2014 the guideline regards housing as a central aspect of health and well-being related provision and this has been reflected in several recommendations. For example, 1.5.13 cites homelessness as the first example of a factor which would prevent the safe and timely transfer of care from hospital.
	SH	Derbyshire County Council	Short	17	1.5.25 and 26	I disagree with commissioning a service for early supported discharge. The 'early' refers to the recovery/rehab period and not the need for further medical intervention. Therefore this should be business as usual. The acute stay should stabilise the medical condition and then the person should be discharged – this is not an early discharge but an on-time discharge. The support provided by the services listed ' home care and rehab...' should take place at home	Thank you for your comment. The Guideline Committee discussed your comment and felt that 'early supported discharge' should remain the phrase used in the guideline. The group reasoned that it is a well-used, widely recognised term, both in the evidence from which the recommendation was derived, and in their own professional practice. The phrase has also been added to the glossary and defined as: "A multidisciplinary service that aims to allow patients to return home from hospital early and receive more rehabilitation support at home".

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						wherever possible. This may mean commissioners looking at what community provision is currently provided and changing this if needed but I think labelling it as early discharge is unhelpful, it makes people think they should still be in.	
	SH	Stroke Association	Short	18	21-26	We welcome the recommendation that relevant multidisciplinary teams should offer family members and other carers of people who have had a stroke training in how to care for them and that this should be needs-led to recognise the fact that the effects of stroke vary widely. This recommendation is in line with NICE stroke quality standard statement 11: 'Carers of patients with stroke have: a named point of contact for stroke information; written information about the patient's diagnosis and management plan; and sufficient practical training to enable them to provide care'.	Thank you for your support.
	SH	Royal College of Surgeons	Short	18	23-26	What would this training look like?	Thank you for your comment. The evidence from which the recommendation was derived (Patel et al. 2004 and Forster et al 2013) stipulated that the training for people with stroke and their carers should be needs-led, but unfortunately it did not provide the grounds on which to make more detailed recommendations about the content or structure of the training.
	SH	Royal College of Speech and Language Therapists	Short	18	1.5.29	For some people with specific communication needs it should recognised that their key communication partners help advocate for them and as such should be routinely involved in the patients care pathway with the patients consent.	Thank you for your support. Advocates are now included in 1.3.5 in order to capture these needs at the point of admission. Communication aids have also been added as an example of a 'reasonable adjustment' which could be made to help accommodate someone during their stay in hospital (1.3.6).
	SH	The Patients	short	18	1.5.29	Involving carers: The Patient Association feels strongly that the hospital- and community-based	Thank you for your comment and support for our recommendations on carers.

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		Association				multidisciplinary teams should treat the family as an important resource for understanding the person's life and needs. Carers must be given support if they will be required to give care which should include training, coaching and respite.	
	SH	Macmillan Cancer Support	Short	18	2	Some people are cared for by friends rather than family, so this could read "treat those close to the person, such as their family..."	Thank you for your comment. In light of yours and other stakeholders' comments 1.5.29 has now been reworded to clarify this point. It have been changed to: "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."
	SH	SeeAbility	Short	18	2	In terms of assessing carers, and support and training for carers, we feel there is a missing section on sharing information with carers, families and supporters. It is important that referrals (such as OT / Physio / SaLT etc) made by the Hospital via the discharge process be made known to the patient's family and supporters.	Thank you for your comment. Involving families and carers in all discussions about a person's care is one of the overarching principles of the guideline. See specifically 1.1.3.
	SH	Alzheimer's Society	Short	18	2	Some people with dementia may not be able to make a decision (lack the capacity to decide) about the best place for them to live when they leave hospital. If this is the case, someone else will need to decide for them. The decision could be made by: a social worker with the help of carers and family; someone who has been given permission by the person to decide on their behalf about the treatment they want (through a health and welfare Lasting Power of Attorney); or a deputy appointed by a court. The statement that the family is an "important resource" does not reflect that, in many cases, carers have legal	Thank you for your comment. The Guideline Committee acknowledges that some people may lack capacity to make certain decisions around their transfer of care from hospital. For this reason, the Committee agreed an overarching principle that if there is any doubt about a person's capacity to consent then the principles of the Mental Capacity Act 2014 must be followed. This is a legal obligation.

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						authority. The guidance should reflect this fact.	
	SH	Macmillan Cancer Support	Short	18	5	Again it would be more inclusive to state ..."include the view and wishes of those who will be caring for the person"	Thank you for your comment. In light of your comment 1.5.30 has now been amended to "With the person's agreement, include the family's and carer's views…".
	SH	Marie Curie	Short	18 -19	7	(1.5.33-36) We are pleased to see training for carers included in this guidance. The King's Fund's 'Better Value in the NHS' report (p.100) finds that 'many carers report not receiving enough support during the last three months of their relative's life […] and systematic reviews highlight the lack of support for informal carers to develop practical skills to care for their dying relative […]'. (1.5.36) We are however concerned that the wording – 'The relevant multidisciplinary team <u>should consider</u> offering family members and other carers needs-led training in care for people with conditions other than stroke' - could lead to variations in whether training is offered to families and carers as there is no firm encouragement to make this offer. A stronger guideline might be that 'Families members and carers <u>should</u> be made aware that needs-led training in care is available if they have a need for it'. One of the priority questions identified through the James Lind Alliance's Palliative and End of Life Care Priority Setting Partnership was related to the information and training needs of carers and families to provide the best care at home, including training for giving medicines. This underlines the importance of this issue.	Thank you for your comment. The wording of these recommendations reflects the strength of the evidence on which they are based. While 1.5.34 (formally 1.5.35) was derived from evidence which was specifically about training for people with stroke and their carers, 1.5.35 (formally 1.5.36) was created by the Guideline Committee through extrapolation of the stroke-specific evidence. It says that the multidisciplinary team 'should consider' similar training for people and carers for people with other conditions in order to show that it is a slightly weaker recommendation. The 'supporting infrastructure' section highlights the need for linking people up with other services in the community. For example, 1.6.1: "Ensure a range of local community health, social care and voluntary sector services is available to support people when they are discharged from hospital "
	SH	Macmillan Cancer Support	Short	18	16	It is positive to see that support and training for carers has been included in the guidance, as this is often an area of unmet need for cancer carers.	Thank you for your comment.

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	SH	SeeAbility	Short	18	16	There is some acknowledgement in 1.5.33 about training/support for carers but the way in which it is written it appears more for informal carers. Commissioners should also be reminded that they may need to review packages of care with providers to reflect provision of equipment and revising support packages/funding to meet changed needs plus time to secure/train staff to meet changed needs.	Thank you for your comment. This recommendation *is* intended for 'informal carers'. In order to avoid any confusion about the use of the term 'carer' in the guideline, the following definition has been added to the 'terms used in this guideline': "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."
	SH	NHS Providers	short	18	18	This seems overly prescriptive. Carers may wish to discuss the practical and emotional aspects of providing care with a practitioner who is not hospital-based, particularly if they have had previous interactions with services.	Thank you for your comment. Recommendation 1.5.32 (formally 1.5.34) refers to both the practical and emotional aspects of providing care because the evidence showed that these were the elements of support that carers (especially those becoming a carer for the first time) most valued around the time of the transition from hospital. The recommendation does not preclude carers from having other discussions with practitioners who are based outside of the hospital; however the intention was that carers would be more prepared before the transfer of care from hospital.
	SH	Royal College of Surgeons	Short	19	19-25	There is no mention of 7 day availability of allied health services whilst in hospital e.g. OT, physio to enable discharge	Thank you for your comment. 7 day availability of allied health services is a huge topic, which is unfortunately beyond the scope of this guideline.
	SH	Royal College of Surgeons	Short	19	8-12	Clear guidance is required for patients and families on other follow up arrangements	Thank you for your comment. The evidence underpinning this recommendation (1.5.37 in the final guideline) did not provide the grounds to give specific guidance on other follow up arrangements. However, other recommendations in the guideline are clear about the importance of providing people and their families with the discharge plan and with details of all health, social care, housing and voluntary sector practitioners who will provide support following discharge. The provision of guidance for patients and families is an area that may be considered as part of the implementation work supporting this guideline.
	SH	United	Short	19	16-	We are not convinced of the value of a phone	Thank you for your comment.

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		Kingdom Homecare Association			17	call in the 72 hours following hospital discharge and consider a domiciliary visit to be the minimum requirement for those assessed as likely to be readmitted in this timeframe, preferably by a District Nurse or CPN	Recommendation 1.5.40 is derived directly from evidence presented to the Guideline Committee that showed that follow up care (including both phone calls and home visits) was vital to reducing readmissions. The committee were unanimous in their agreement about this recommendation, including that it should be focussed on people at risk of admission, rather than just older people and that the timeframe should be 24-72 hours.
	SH	The Patients Association	short	19	1.6	Supporting infrastructure: the range of local services need also to be designed and offered informed by cultural sensitivities of local patient populations.	Thank you for your comment. The evidence from which this recommendation was derived did not give the Guideline Committee grounds on which to stipulate the nature of the services provided post-discharge. However, person centred-care is an overarching principle of the guideline. Treating the person with dignity and respect would necessitate an understanding of culturally-specific needs. Recommendation 1.2.3 now specifies that discussions about advance care plans should cover • religion, culture and spirituality.
	SH	Royal College of Nursing	Short	19	1.6.1	Temporary adapted accommodation should be available for people whose homes are awaiting adaptation. Every reasonable intervention should be given priority to enabling people to move out of hospital settings and to maintain them within their own homes while they are awaiting adaptions to be completed. Urgent should mean urgent and a timeline should be defined	Thank you for your comment. Reablement is a significant topic and is only covered in this guideline where it involves a transition between a hospital and home setting. A NICE social care guideline on Intermediate care – including reablement is currently in the process of development.
	SH	The Patients Association	short	19	1.5.38	After transfer from hospital, community-based health and social care practitioners MUST maintain contact with the person after they are discharged; this is absolutely vital for many people's long-term health and wellbeing. They should also liaise with the GP and the community based nurse to ensure the patient's	Thank you for your comment. Within NICE guidance the use of 'must' within a recommendation denotes a legal obligation or when not adhering to the recommendation may cause serious harm. We acknowledge the importance of maintaining contact with the person after discharge but, unfortunately we cannot add additional emphasis to this through changing the wording in the suggested manner.

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						holistic needs are being met.	
	SH	Crisis	Short	19	1.5.40	Homeless people are far less likely to be registered with a GP than the general public, Homeless Link's most recent health audit[11] of homeless people found however, that despite the majority of people surveyed reporting that they were registered with a GP; many were not receiving help for their health problems. They found that 15 per cent of respondents with physical health problems were not receiving support, while 17.5 per cent of those with mental health issues and 16.5 per cent with alcohol issues would like support but are not receiving it. Additionally, 7 per cent of respondents had been refused access to a GP or dentist within the past 12 months. The same report found that 36 per cent of homeless patients had nowhere suitable to go when leaving hospital. A lack of suitable discharge protocols for homeless people have obvious health implications in terms of people's recovery, but also likely deters them from entering hospital in the first place. If the person is being rehoused in a new area NHS staff should help the person register with the GP and if they are being rehoused in their local area, checks should be made to see if they are already registered and if not then they should be	Thank you for your comment. The section 'people at risk of hospital readmission' addresses this issue. Recommendation 1.5.27 advises the discharge coordinator to refer people at risk of readmission to relevant health and social care staff in the community before they are discharged.
	SH	Stroke Association	Short	19	3	The guidelines recommend reviewing carers training and support needs every 6 months and yearly, which we support. However there is	Thank you for your comment. The recommendation to which you refer (1.5.36 in the final guideline) is actually intended to refer to the person (patient's) 6-month and annual reviews. In

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[11] Homeless Link, Annual Survey of Support for Single Homeless People (2015)

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						nothing in the guidance about assessing and reviewing the needs of patients themselves. Longer term review of people after stroke to support recovery is recommended in the National Stroke Strategy at 6 weeks, 6 months and annually. The most recent SSNAP data found that whilst the vast majority of patients after stroke were eligible for a 6 month review, this is currently happening in only 21.6% of cases.	other words, when the person's needs are reviewed, so too should the needs of their carer.
	SH	Marie Curie	Short	19	6	(1.5.37) For people who are approaching the end of their life, change and deterioration might happen very rapidly. Carers and family should be supported accordingly.	Thank you for your comment. The Guideline Committee agrees with your point, although they decided not to change the wording of the recommendation. There are specific recommendations about providing support and training for carers and as with all the recommendations, this should be provided in a way that is person centred and responds to the needs of the individuals.
	SH	Action on hearing loss	Short	19	14	A bullet point should be added to Recommendation 1.5.12 to recognise the importance of communication needs in the safe, timely transfer of care from hospital. As discussed in comment 1, unaddressed hearing loss can lead to social isolation and increased risk of depression, dementia, and other forms of sensory loss. Discharge planning should consider whether arrangements for care and support meet the communication needs of people with hearing loss. Possible considerations include: - Social care managers and practitioners should be alert to the early signs of hearing loss, record instances of hearing loss and also be aware of the GP referral pathway for assessment and treatment (In line with NICE's quality standard for the mental wellbeing of	Thank you for your comment. The recommendation to which you refer (recommendation 1.5.13 in the final guideline) is not intended to provide an exhaustive list of all possible factors that could prevent a safe, timely transfer from hospital. However the Guideline Committee agrees with you about the importance of supporting people with communication needs throughout transitions. This is why an overarching principle was developed to state that people at risk of less favourable treatment or with less access to services should be identified and supported. This includes people with communication difficulties. Recommendation 1.3.2 also specifies that at the point of admission, the admitting team should identify and address people's communication needs. Recommendation 1.3.3 also states that health and social care practitioners, including care home managers and out of hours GPs responsible for transferring people into hospital should ensure the admitting team is given all available relevant information, which includes communication needs.

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						older people in care homes[12]). - The provision of assistive equipment in the home such as an amplified telephone or devices that use flashing lights of vibrating pads to alert the person when a phone, doorbell and fire alarm is ringing. Under the Care Act 2014, local authorities must provide community equipment up to the value of £1000 (see comment 14 for further information) - Staff should ensure that hearing aids are working and are with the patient when they move from one setting to another, and that there is a clear process for where to keep the hearing aids and ensure they are used. - Care staff must display good deaf awareness (speaking slowly and clearly and facing the person whilst speaking) and are able to carry out basic hearing aid maintenance such replacing batteries, ear mould cleaning and retubing. Care staff should also be familiar with assistive equipment which may benefit people with hearing loss such as hearing loops, amplified telephones and TV listeners. - The care home/home environment must be suitable for people with hearing loss, for example ensuring care homes have low levels of background noise. Poor acoustics in rooms such as echoes	

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[12] NICE (2013) Mental wellbeing of older people in care homes. QS50

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						from hard surfaces can cause high levels of background noise. Soft furnishings can help minimise this problem. To enable people with hearing loss who lip read to understand what is being said, rooms should be well lit and free of shadows or glare.	
	SH	Airedale NHS Foundation Trust	short	19	16	The recommendation around keeping contact following discharge is challenging when dealing with large rural areas. The use of telemedicine is in use in this Organisation for some patient groups.	Thank you for your comment. The Guideline Committee acknowledges the challenges you describe. The recommendations are intended to be aspirational yet realistic. The Committee did not review specific evidence about the use of telemedicine in the context of transitions so were unable to make specific recommendations in this area.
	SH	Foundations	Short	19	19	Home Improvement Agencies offer a range of service models that can support people being discharged from hospital. The schemes combine support for the client and carer combined with practical interventions provided Handypersons. The caseworker ensures the client have adequate support on discharge, can check benefits and other support needs. Some models are based upon the caseworker creating the link between the patient in hospital and their needs at home to ensure that the have enough support within a safe and habitable environment. The Handyperson carries out Home Safety Checks, minor adaptations, heating and security checks and any practical measure that supports the discharge and helps prevent any readmission. These could include fitting rails, moving beds and home safety checks. Such schemes reduce the need for multiple hand-offs to a range of services and the consequent risk of support being delayed or omitted.	Thank you for your comment and for the helpful information you provide. The examples you give may be reviewed in the context of our work to support the implementation of the guideline.
	SH	Action on	Short	19	28	Examples of community services which are	Thank you for your comment. The list of examples in this

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		hearing loss				useful to people with hearing loss should be added to recommendation 1.5.14 including: - Hearing therapy - Specialist counselling services - Peer support groups - Lipreading classes	recommendation is not intended to be exhaustive. The Guideline Committee did not feel that it was appropriate to highlight one group's needs over others (unless the evidence dictated this, or a unanimous consensus was reached). However, in light of yours and other stakeholders' comments about the needs of people with sensory impairment the Accessible Information Standard is referenced in the overarching principles of the guideline.
	SH	Royal College of Surgeons	Short	20	14-30	Assessment of capacity can be difficult and whilst information on Capacity Act is included in mandatory training, this is often done well enough. Training on communication with patients and families and supporting shared decision making	Thank you for your comment. The Guideline Committee agreed with your point about training on communication with patients and families, which is why there is a bullet point on 'discharge communications'. However, recognising that communication about sensitive issues such as end of life care preferences can be particularly challenging, they chose to add a further bullet point which reads 'how to have sensitive discussions with people about end of life care needs'.
	SH	Action on hearing loss	Short	20	12-16	Examples of housing adaptions which may benefit people with hearing loss should be added to recommendation 1.5.18. these should include: - Amplified telephones which amplify voice and have an amplified ringtone. Some may have a built in light that flashes when the phone is ringing - Hearing aid compatible telephones – telephones with hearing loop settings - Conversors – portable listening devices which enhance directional sound - Vibrating pads that respond to ringing smoke alarms/doorbells/telephones	Thank you for your comment. As the population of the guideline is all adults with social care needs who are transitioning between hospital and the community the Guideline Committee did not feel it was appropriate to highlight any one group's needs over another. Please note that the focus of the guideline was on general principles of transition and recommendations were only made on specific conditions where there was specific evidence
	SH	Action on hearing loss	Short	20	1-4	Recommendation 1.5.15 should be reworded to include requirements for accessible information. For example "the discharge coordinator should give the plan to the person in a format they can	Thank you for your suggestion. The Guideline Committee chose not change the wording of this recommendation. This is because the importance of providing information in an accessible format is covered in the overarching principles. In

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						understand". This would bring the recommendation in line with the Accessible Information Standard which states that information on care and support must available in accessible formats for people with sensory loss and learning disabilities. For people with hearing loss, accessible formats include written information in plain English, andpeople who are deaf who use BSL may require BSL translation of written information either through a qualified BSL interpreter or BSL video translation (where a BSL translation of written or typed information is recorded on video).	the final guideline, recommendation 1.1.6 refers to the Accessible Information Standard so we thank you for highlighting this new requirement.
	SH	United Kingdom Homecare Association	Short	20	11-13	This section appears to be NHS and institutionally based, the education and development of all care staff in every component of the transitional care element of the health economy should be of equal merit particularly for 'front line staff' who may initiate transfer to hospital or receive discharged people from institutional care as it will be critical for them to have first-hand knowledge of procedures	Thank you for your comment. The Guideline Committee reached a consensus to broaden this recommendation so that 'all relevant staff are trained in the hospital discharge process'.
	SH	Foundations	Short	20	1	This should also include Community Housing support services such as HIAs.	Thank you for your comment. The recommendation to which you refer (1.6.3 in the final guideline) incudes local health, social care and voluntary services, which the Guideline Committee believes is sufficiently comprehensive. This is particularly so because on the cover page of the guideline, there is a specific reference to the fact that all health, health related provision (including housing) and care and support are covered by the guideline. The final guideline has also been edited slightly to increase the prominence of housing needs and housing practitioners in certain recommendations, for example housing specialists are now listed as examples of practitioners making up the hospital and community based multi-disciplinary teams.

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	SH	The Patients Association	short	20	1.7	Training and development: this should also include training on 'culture and how not to offend' as well as 'unconscious bias 'to enable patient centred care.	Thank you for your comment. The Guideline Committee chose not to make these changes because the delivery of person centred care is an overarching principle for the delivery of all the recommendations. The Guideline Committee did however agree to add a bullet point about training in conducting sensitive discussions with people about end of life care, which they feel addresses your point about avoiding offending people during discharge communication.
	SH	Royal College of Nursing	Short	20	1.7	Our members commend discharge training and education that focuses on particular patient groups.	Thank you for your support.
	SH	Royal College of Speech and Language Therapists	Short	20	1.7.1	It is essential learning and development plans are in place to support staff to learn appropriate communication skills. Competencies related to communication must be embedded from induction to specialist practice. Furthermore, we support ongoing supervision to support staff to adapt their communication and build up understanding of the communication needs of individuals. Staff adaptations could include simplification of language, use of a range of ways of communicating or observing and responding to the individual's behaviour.	Thank you for your comment and for your ideas about implementing the training recommendation. Unfortunately the research reviewed by the Guideline Committee in this area did not provide evidence to support such detailed guidance about the delivery of training. However, please note that a research recommendation has been made on 'training for hospital and social care practitioners'.
	SH	Foundations	Short	20	7	This should also include statutory and not for profit housing services.	Thank you for your comment. The recommendation to which you refer has actually been deleted from the final guideline and amalgamated with recommendation 1.6.3. As it stands, 1.6.3 includes 'local health, social care, and voluntary sector services', which the Guideline Committee believes is sufficiently comprehensive. This is particularly so because on the cover page of the guideline, there is a specific reference to the fact that all health, health related provision (including housing) and care and support are covered by the guideline. The final guideline has also been edited slightly to increase the prominence of housing needs and housing practitioners in

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							certain recommendations, for example housing specialists are now listed as examples of practitioners making up the hospital and community based multi-disciplinary teams.
	SH	Age UK	Short	20	9	Additional sentence: Commissioners should consider assessing the local area for provision of voluntary and community sector providers and look to develop the market where provision is low. The Care Act already includes a duty on local authorities to promote diversity and quality in the market of care and support providers and we would expect them to work with NHS commissioners in achieving this.	Thank you for your suggestion. The Guideline Committee chose not to add your suggested wording because NICE social care guidelines do not make recommendations specifically directed at commissioners or about issues around shaping the local care and support market.
	SH	Sense	Short	20	10	Add to the list of training needs understanding of the Care Act as it relates to assessment and provision of care and support. Once people leave hospital their care and support needs are likely to be met by social care. Hospital staff need to understand how this process works if they are to understand what might be available on discharge. This should include knowledge of how to get an appropriate assessment for someone who needs a specialist assessment such as a deafblind person.	Thank you for your comment. The Guideline Committee chose not to make the specific changes you describe but they did agree to add a bullet to the aspects of training, which reads 'how to arrange, conduct (where appropriate) or contribute to assessments for health and social care eligibility'.
	SH	Foundations	Short	20	11	Many front line professionals in health and social care lack a basic understanding of how a person's housing situation ie cold, damp, inability to access facilities etc, can impact on someone's health and well-being. For instance a person being discharged to a home without adequate heating is at severe risk and will often need support in organising the boiler repair. Foundations would recommend '**Healthy Homes' training for Health and Social Care**	Thank you for your suggestion. The Guideline Committee believes that the issues you raise are covered by recommendation 1.7.1 which states that training should include 'learning how to assess a person's home environment (home visits)'. The research that the Committee reviewed did not provide the basis to recommend specific training programmes.

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						professionals.(See attached flier of a local course provided by WE Care and Repair.) The training will ensure that staff will be aware of the impact of housing issues and of referral routes available to remedy issues identified. Home Improvement Agencies are usually the first point of call offering practical services provided by housing professionals such as Home Safety Checks, minor/major adaptations, support with essential repairs and maintenance etc. Health Homes Flier.doc	
	SH	Guild of Healthcare Pharmacists	Short	20	14	We suggest that the term 'medicines optimisation' is used rather than 'medicines management'. The latter term is a part of the wider medicines optimisation agenda which is a patient-focused approach to getting the best from investment in and use of medicines that requires a holistic approach. Most importantly medicines optimisation differs from medicines management in that it focuses on outcomes and patients rather than process and systems.	Thank you for your suggestion, with which the Guideline Committee agreed. The change to the wording in recommendation 1.7.1 has been made and medicines optimisation has also been defined in the guideline glossary.
	SH	Age UK	Short	20	29	We strongly support this point on risk enablement.	Thank you for your support.
	SH	Age UK	Short	21	General	Regarding the request for examples of practice, some of the challenges around individual goal setting and coordination are being addressed through Age UK's integrated care programme. For more information, contact tom.gentry@ageuk.org.uk.	Thank you very much for supplying these details.

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	SH	Action on hearing loss	Short	21	18-23	A recommendation should be added to People at Risk of Readmission subheading on hearing assessments. For example "the discharge coordinator should refer people with unaddressed hearing loss for a hearing assessment before they are discharged". As discussed in comment 1, unaddressed hearing loss can lead to social isolation and depression, and also increases the likelihood of developing dementia. The timely provision of hearing aids improves communication, quality of life and independence of people with hearing loss. Research shows that hearing aids reduce the social isolation and depression, and new evidence suggests they reduce the risks of developing dementia (see comment 1 for references). Hearing aids enable people with hearing loss to communicate with friends, family and health and social care practitioners. People with hearing aids are more likely to understand the information given and benefit from health and social services, which will reduce the likelihood of future hospital readmissions.	Thank you for your comment. The evidence from which the recommendations for people at risk of readmission were derived only related to specific populations. For example, Sadowski, 2009 related exclusively to a homeless population. The Guideline Committee created 1.5.28 to reflect this. As the evidence did not cover people with unaddressed hearing loss the committee did not feel it was appropriate to make a reference to them at this point. However, the communication and information sharing section of the overarching principles now references the Accessible Information Standard.
	SH	Royal College of Speech and Language Therapists	Short	21	1.7.2	We are unsure why are only physiotherapists and occupational therapists listed here? Why are speech and language therapist not listed here?	Thank you for your comment. This recommendation has now been deleted and recommendation 1.7.1 now refers to 'all relevant staff'. In light of your and other stakeholder comments 'therapists' (which covers speech and language therapists) has now been added to the community and hospital-based multidisciplinary team members.
	SH	Macmillan Cancer Support	Short	21	10	The significant challenge represented in recognising that everyone receiving care is an individual and equal partner is the required change in culture, as well as training and	Thank you for your response to this consultation question. The Guideline Committee agreed that culture change is key factor in achieving person-centred care and support in the context of this guideline. We have reflected your points in the three key

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						resources to support meaningful informed choice.	challenge areas in the implementation section.
	SH	Macmillan Cancer Support	short	21	13	Poor coordination of care and poor communication between and within teams can lead to reduced outcomes and poor experience of care. There are clear examples of technology and innovation working to improve coordination and therefore impacting service demand (improving efficiencies etc). For end of life care a key tool in enabling the sharing of individual care needs and preferences are electronic data sharing systems such as Electronic Palliative Care Coordination Systems (EPaCCS). EPaCCS have expanded since their use was pioneered following the recommendation in the End of Life Care Strategy (2008). A recent evaluation of established EPaCCS demonstrated that they have enabled up to 80% of people who were included in EPaCCS to die in their preferred place of choice, which delivered cost savings to the NHS through reductions in acute hospital admissions and bed use.[13] NHS Improving Quality estimated yearly savings of up to £133,200 where EPaCCS are used.[14] Macmillan continues to develop technology and IT to support improvements in care throughout the cancer pathway. Our experience is that implementation of these resources is often hindered by lack of connected IT infrastructure (e.g. wireless) in the NHS and	Thank you for your response to this consultation question. We have made reference to the evaluation of EPaCCs as a possible source of information that it may be helpful for practitioners to refer to in implementing this guideline. We will bear in mind your other points as we consider activities or tools to support implementation of this guideline.

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[13] National choice revew
[14] Economic Evaluation of the Electronic Palliative Care Coordination System (EPaCCS) Early Implementer Sites, NHS Improving Quality, February 2013

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						between organisations. The workforce needs to be supported to utilise the technology effectively. In particular we recognise that cultural changes will be required of health professionals to support self management and data sharing.Co-ordination of care requires investment in face-to-face contact between team members, with education and training bodies at all levels to enable and support team working.	
	SH	Macmillan Cancer Support	short	21	18	As highlighted above there are 2 main challenges we would add in addition to the 3 identified for implementation: 1. A lack of capacity in hospital and community services to undertake person centred assessment and care planning and support coordinated care. 2. A need for oversight of health, social care and third sector services provided in a locality that can be utilised to support people after discharge and that this knowledge is updated and current Macmillan believes that our piloting of Support workers as part of One- - One Support in cancer, demonstrates that a combination of increasing capacity through the introduction of specific coordinator roles, standard implementation of HNA; supporting self identification of concerns and improved information flow would address this challenge.	Thank you for your additional comments about challenges for implementation. We will take account of these as we consider priorities for implementation support. We also encourage organisations with relevant practice examples to submit these for NICE's database for shared learning and further dissemination.

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	SH	Age UK	Short	22	General	In the section on challenges for implementation, we believe there needs to be a greater emphasis on housing. Housing is inconsistently thought of as a component of effective integrated care, but research by Leonard Cheshire found that: "one third (37 per cent) of councils told us that they are not planning to spend any of their [Better Care Fund] allocation on housing" (*The long wait for a home*, Leonard Cheshire Disability, 2015); another report found "of local authorities identified as pioneers on integration … nearly three quarters (73 per cent) did not consider housing to be a key component in the integration of health and social care" (*Health and housing: From consensus to practice*, MHP Health, 2014). In meeting this challenge, health and social care commissioners should be encouraging an integrated approach to home support by involving home improvement agencies and occupational therapists in the strategic planning, delivery and investment in services, especially where there are gaps in provision. This has particular implications for the guidance on page 15 on discharge planning. The process, including the effectiveness of a discharge coordinator, is highly dependent on the availability of local home support services with funding arrangements in place. Guidance on both the legal requirements and best practice in this regard can be found here: https://homeadaptationsconsortium.files.wordpress.com/2013/09/dfg-good-practice-guide-30th-sept-13.pdf.	Thank you for your comments on this consultation question and for providing the additional information about local home support services. We have emphasised that, in line with the Care Act 2014, this guideline covers health and health-related provision (including housing).and other care and support. We will draw upon your comments and the information you have provided as we consider priorities for activities or further tools to support implementation of this guideline.
	SH	Royal	Short	22	2-4	It is important to ensure that people are involved	Thank you for your comments and the additional information

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		Pharmaceutical Society				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. 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	which we will draw upon as we consider implementation support for this guideline. We will be encouraging organisations with relevant practice examples to submit these for the NICE database for shared learning and for wider dissemination.
	SH	Royal Pharmaceutical Society	Short	22	20-21	It is important that information about medicines and any changes, including the reasons for those changes, are communicated to anyone involved in that person's care. The information at discharge should include this and should be available to all those providing care for the patient, including the community pharmacist.	Thank you for your comment. The Guideline Committee were very aware of the importance of sharing information about medicines at transitions and so have highlighted NICE guidelines on medicines optimisation and managing medicines in care homes at recommendation 1.1.4
	SH	NHS Providers	short	22	1	We welcome the recognition within the guidelines of the challenges that implementation is likely to pose for providers.	Thank you for your comment. Coming from a wide range of perspectives – including providers - the Guideline Committee were very mindful of the context and implementation challenges facing health and social care providers.
	SH	Age UK	Short	22	8	After "suits their needs" add: and meets their goals for care	Thank you for your comment. We have added this.
	SH	NHS Providers	short	22	20	Under this heading or in a separate heading, it would be helpful if the guidelines also acknowledged the challenges related to systems integration and interoperability, as outlined in comment number 13 of this response.	Thank you for your comment. The Guideline Committee agreed that Ensuring effective communication is one of the three biggest challenges that could have the greatest impact if implemented. We have highlighted the importance of making best use of technology to enable data sharing between practitioners involved in the care and support of people in their area. We have also highlighted the National Information Board's framework for action which intends that by 2020, all care records will be digital, real-time and interoperable.
	SH	City of York	Short	23	General	**Challenges for implementation –** Communication in all aspects is a major	Thank you for your comment. Ensuring effective communication of information between practitioners at all

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		Council Adult Social Services				challenge in this area – particularly communication into and out of the hospital – ie transferring information about the person and their particular needs when they are admitted to hospital, especially in an emergency; and timely information about their treatment and ongoing needs on transition to home or care home.	stages through the person's journey into hospital, during their stay and returning home has been identified by many stakeholders. Guideline committee members agreed that this is likely to be a key challenge area and so we have reflected this in the implementation chapter.
	SH	Action on hearing loss	Short	23	8-12	Recommendation 1.5.38 should be reworded to include accessible contact methods. For example: "It involves making sure the person is able to contact them when they need to, in line with standards for accessible communication and information". This would bring the recommendation in line with the mandatory Accessible Information Standard which states that contact methods must be accessible for people with sensory loss and learning disabilities. For people with hearing loss, suitable contact methods include - Textphones – devices where a person can type what they want to say rather than speaking through a mouthpiece - Next Generation Text (NGT) - a service which allows people with hearing loss to contact someone using a telephone using a textphone or the NGT app on a smartphone, tablet or PC. NGT service connects the person to relay assistant who reads their written messages aloud and types the reply - Email - SMS text - Instant messaging - BSL video relay – this is where a	Thank you for your comment. In light of your and other stakeholders' comments the overarching principles section of the guideline now links to the Accessible Information Standard.

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						BSL interpreter translates what is being said to a BSL user during a video call	
	SH	Action on hearing loss	Short	23	22-25	Recommendation 1.6.1 should include examples of local services that may benefit people with hearing loss, including: - Hearing therapy - Specialist counselling services - Peer support groups - Lipreading classes	Thank you for your comment. As the population of the guideline is all adults with social care needs who are transitioning between hospital and the community the Guideline Committee did not feel it was appropriate to highlight any one group's needs over another. Please understand that the list given in this recommendation is not exhaustive.
	SH	Age UK	Short	23	4	Add at the end of the sentence: , including awareness of the dementia and cognitive health needs.	Thank you for your comment. The 'challenges' section of the guideline has now been reworded and reordered. However, people with dementia and cognitive health needs are covered by: For health and social care practitioners this will mean ensuring that: • People who are at risk of less favourable treatment or less access to services (such as people who are homeless or with mental health problems) are identified and supported, and reasonable adjustments are made, to ensure that they can make informed choices.
	SH	City of York Council Adult Social Services	Short	24	General	**Training for hospital and social care practitioners –** we would support a collective approach to training in this area; including shared responsibility for managing the process; in a person-centred way; and a shared ownership of the outcomes of transition from hospital to home or care home.	Thanks for your comment and your support for this research recommendation. Please understand that this is a recommendation for research to assess the effectiveness of training interventions rather than a recommendation for the content of training interventions themselves.

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						This would need to include training regarding effective communication and working together; and addressing and overcoming cultural differences. One area of concern is the lack of knowledge amongst health staff regarding their responsibilities under the Mental Capacity Act 2005 and the implications of the Care Act 2014. Joint health and social care training would be very helpful in these areas.	
	SH	Derbyshire County Council	Short	24	general	Question 3: 3.1 Training for hospital and social care practitioners: A brilliant topic! A key challenge we have identified in achieving hospital discharges/ transfer to non-residential settings is the very different perspective on 'risk' held by hospital based staff to those based in/ working in community settings; and we are planning to use some of our BCF funding allocated for OD to see if we can run some workshops/ fund backfill to enable staff to shadow colleagues in the community. I'm not aware of any similar research projects.	Thank you for your comment and your support for this research recommendation. Thanks also for passing on information about your plans to run a shadowing scheme. We aim to highlight practice examples for shared learning as part of our implementation support so this information is helpful.

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	SH	Carers UK	Short	24	1	Research Recommendations: We especially welcome the first recommendation for research into 'Training for hospital and social care practitioners' which is to look at 'the effect of hospital discharge or transitions training for health and social care practitioners on achieving successful transfers from hospital to home or the community? (Including specifically the effects on formal and informal carers, and on avoidable readmissions?)'. As stated earlier, research conducted by Carers UK shows that when carers are not consulted with over the discharge of the person they care for, there is an increase in readmission to hospital. If carers are consulted about the discharge, it can better ensure a seamless transfer between hospital and home.	Thank you for you response and for your support for this research recommendation.
	SH	Royal College of Speech and Language Therapists	Short	24	3	<u>Draft research questions</u> We question why the research questions have such an emphasis on mental health?	Thank you for your comment. The research recommendations were developed in response to the uncertainties and gaps in evidence identified by the Guideline Committee. Both of the questions which reference mental health are aimed at a population who have combined mental health and physical health care needs. Identification, assessment and (self-) management of mental health care needs (including those of people with dementia, delirium, and depression or anxiety) undergoing transition from a general hospital setting were identified as areas which required more research.
	SH	Royal College of Nursing	Short	24	3	Our members consider that the research questions are interesting but anecdotally feel that it is community health and care professionals who would know what will and will not work best for people outside of hospital. They have asked that future research should consider looking at the question of 'in-reach' to see if evidence could be gathered for the effectiveness of this? The broad research	Thank you for your comment. We agree that 'in-reach' would be a valuable topic to research. However research recommendations have been made based on gaps or uncertainties in the evidence review. 'In-reach' is a far broader topic and beyond the remit of this guideline.

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						question of whole system experience and impact needs to be considered alongside effectiveness and cost-effectiveness.	
	SH	The Patients Association	short	24	3.1	Training for hospital and social care practitioners should also include training on 'culture and how not to offend' as well as 'unconscious bias' to enable patient centred care. Health disparities and lower quality care are exacerbated when healthcare professionals fail to address ethnicity, culture and language in the provision of health services (Wilson-Stronks 2008).	Thank you for your comment. We acknowledge the importance of culturally sensitive practice and training (refer to the Equalities Impact Assessment for this guideline for more information). However, please note that this is a recommendation for research to assess the effectiveness of training rather than a recommendation for the content of training interventions themselves.
	SH	Derbyshire County Council	Short	25	general	3.2 Self- managements support for people with mental health problems: we are working with our CCG colleagues around using our Direct Payments processes and structures to support the increase in Personal Health Budgets (PHBs); having just finished a meeting today with CCG colleagues, I know one of them is planning to target their initial work on people with mental ill health and another is looking to roll them out to IAPT and people with anxiety. I don't know what national research, if any, is being undertaken to evaluate the effectiveness of PHBs across the range of people using NHS provision?	Thank you for your comments. This research recommendation would not especially call for research that looks at Personal Health Budgets (PHBs). Rather it looks to identify components of successful interventions to help understand what works in supporting people with mental health problems who also have a physical health problem to self-manage as they move between home and hospital settings.
	SH	Derbyshire County Council	Short	25	general	3.3 Mental health interventions to support discharge from general inpatient hospital settings: the only comment I would make is that our BCF local target is around increasing diagnosis of dementia – and this was taken from the national options list of potential local targets provided by the DH i.e. we can't be the only place with this as a target…and therefore increasing investment aimed at improving both the rate of diagnosis as well as the experience of the individuals. On a slightly parallel topic, we	Thank you for your comment and for raising the issue of BCF local targets around increasing diagnosis of dementia. We will consider this as part of our implementation strategy. The Guideline Committee acknowledge the dangers of malnutrition for older people transitioning in and out of hospital. This was part of the rationale for including a dietitian within the hospital-based multidisciplinary team (1.3.7).

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						have now twice run an annual nutrition survey (jointly with our local acute/ community hospitals; Age UK and a sample of local care homes) – one of the things we have identified and are going to undertake more research on is to better understand the levels of malnutrition in care home settings i.e. are people being discharged from hospital malnourished? Is there practice that needs to be improved in care homes? Etc. Our joint working group has identified a number of actions etc. that are being taken in the hospitals locally to identify and then support older people with dementia to ensure that they are adequately nourished and hydrated in hospital settings.	
	SH	The Patients Association	short	25 -26	3.3-3.4	The Patients Association agree that costs and outcomes for patients and carers need to be measured, including changes in mental health and carers' outcomes. However, the meaning of the term 'cost' seems to have greater emphasis (weight) than patient outcome within the NHS, while we would argue the latter is more important.	Thank you for your comment. Cost-effectiveness analyses conducted as part of the NICE social care evidence reviews always consider a range of outcomes (patient quality of life, caregiver burden) alongside costs.
	SH	Marie Curie	Short	25	22	(3.3) Marie Curie agrees that supporting discharge to community care for people with dementia should be a key research question. Evaluation from Marie Curie's Dementia Service in West Wales evidences good practice in this area. This involves 3 nurses with mental health and end of life experience providing a case management and coordination role to support nurses and patients in care homes and in the community. 57% of health professionals strongly agreed that the service helps the patients to achieve their preferred place of care and death; 88% of carers agreed that the	Thank you for your support and for this example of good practice. As part of our implementation support we aim to highlight practice examples for shared learning.

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						service keeps patients out of hospital and 87% of patients achieved their preferred place of death. Please contact Natasha.Wynne@mariecurie.org.uk if you require further information.	
	SH	Wirral Older People's Parliament	Short	26	general	Question 3 Geriatric assessment. The very word geriatric is seen as ageist and derogatory by the older population. Nevertheless, a holistic assessment is almost always thought to be in the interests of the population under discussion. We would strongly support research into outcomes for cohorts having full holistic assessment and care, plus similar cohorts in hospital under specialist consultants, without a "geriatric" input.	Thank you for your comment. The Guideline Committee felt that the terminology used in the review evidence and their own experience backed up the use of the phrase 'Comprehensive Geriatric Assessment'. While 'geriatric' has derogatory connotations, 'geriatrician' is still the primary terminology used for specialists in the care of aged people.
	SH	Derbyshire County Council	Short	26	general	3.4 Geriatric assessment and care: no knowledge of similar research; but hospitals do use assessment units, often predominantly used for older people.	Thank you for your comment and for sharing this information about assessments units used for older people.
	SH	Stroke Association	Short	26	9-10	The guideline says that 'research is needed on what measures are effective in preventing, managing or resolving dementia or delirium when a person is transferred'. We believe there is a gap in research around the effective diagnosis of cognitive impairment and dementia, and also the ability to distinguish between the two. Whilst cognitive impairment and delirium may be 'resolved', this is not the case for those with dementia and different tailored management will be required for different patients and their respective level of cognitive impairment, delirium and dementia. Accurate diagnostic tools are a necessary first step to be able to identify those patients who need	Thank you for your comment. We acknowledge the problematic nature of grouping organic brain disorders with functional brain disorders under the umbrella term of mental health, and also understand the complexities of distinguishing between the two. However for the purposes of this guideline we felt it was important to consider anyone within this population who has coexisting physical and mental health care problems (which may go unnoticed within a general hospital setting).

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						measures to prevent, manage and resolve dementia or delirium. Currently, the approaches to cognitive testing are inconsistent and the information, advice and support provided to patients and their families on this matter is also inconsistent. This applies both before and after patients are discharged, as cognitive and psychological problems may improve, worsen or present for the first time post-discharge.	
	SH	Derbyshire County Council	Short	27	general	3.5 Assessment at home to improve hospital discharge success rates: our view is that 'at home' or at least in a non-hospital setting, certainly for older people with dementia, is more likely to provide a 'true' picture of the individual and their needs. And also, knowing that an older person (as well as their family), who is in an alien environment (a hospital bed), having been ill/ had an operation – is very likely to feel too week/ poorly/ disorientated/ scared of how they will manage at home – is not likely to have an assessment that carries forward much more than a few days/ weeks…and it is not the time/ place to make a decision that has a long-term impact on them i.e. moving permanently into a residential/ nursing home. I am not aware of any research – but we, as have as some other local authorities, have/ do use NHS Winter Pressures/ s. 256 transfer/ and now BCF to fund residential care home 'discharge to assess' beds; these are over and above the bed-based re-ablement and intermediate care provision we have in place – with the explicit purpose of both freeing up inappropriately used hospital beds and of facilitating better assessments (and targeted interventions).	Thank you for your comment and for sharing information about current practice regarding the discharge to assess model.

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	SH	The Patients Association	short	27	3.5	Assessment at home to improve hospital discharge success rates: The Patients Associations agrees that more research is needed to compare the effectiveness of assessment in hospital with home assessment after discharge. Anecdotally, older people would prefer to stay in a 'known environment', preferably their home so it is important to explore the feasibility and acceptability of home assessment compared with hospital assessment	Thank you for your comment and your support for this research recommendation. The discharge to assess model was discussed by the Guideline Committee as an evolving model which has added value as a way of assessing older people in a known environment. The Committee anticipate that future research will demonstrate its effectiveness – especially for older people.
	SH	Royal College of Speech and Language Therapists	Short	28	4	We are concerned that the Care Plan in the glossary is defined as something that is nice to have and lacks emphasis of its importance. Furthermore, a care plan should always be in a format which the patient can understand.	Thank you for your comment. We are now going to signpost to the Think Local Act Personal definition of 'care plan' which is: "A written plan after you have had an assessment, setting out what your care and support needs are, how they will be met (including what you or anyone who cares for you will do) and what services you will receive. You should have the opportunity to be fully involved in the plan and to say what your own priorities are. If you are in a care home or attend a day service, the plan for your daily care may also be called a care plan." The guideline references the care plan at each stage of the transition process so practitioners following these guidelines should recognise the importance of creating and adhering to it. Ensuring that information is offered in an accessible format is an overarching principle of the guideline.
	SH	Royal College of Speech and Language Therapists	Short	28	4	We question why the list of the community-based multidisciplinary team does not include therapists, such as speech and language therapists or physiotherapists?	Thank you for your comment. In light of your comment therapists has been added to the list of members of the community-based multidisciplinary team.
	SH	Derbyshir	Short	28	14	Community-based MDT – can this please	Thank you for your comment. In light of your comment

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		e County Council				include OT and physio – they are the main health individuals involved post discharge for adults with complex/rehab needs.	therapists has been added to the list of members of the community-based multidisciplinary team.
	SH	Guild of Healthcare Pharmacists	Short	29	15	We suggest that the term 'medicines optimisation' is used rather than 'medicines management'. The latter term is a part of the wider medicines optimisation agenda which is a patient-focused approach to getting the best from investment in and use of medicines that requires a holistic approach. Most importantly medicines optimisation differs from medicines management in that it focuses on outcomes and patients rather than process and systems.	Thank you for your comment. In light of your comment and those from other stakeholders, we have replaced the term 'medicines management' with 'medicines optimisation'. This is also in keeping with the NICE guideline on medicines optimisation, which is now cross referenced in 1.1.4.

Registered stakeholders http://www.nice.org.uk/guidance/GID-SCWAVE0712/documents/stakeholder-list