NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Social care guideline scope

1 Guideline title

Coordinated transition between health and social care

1.1 Short title

Transition between health and social care

2 Remit and background

The National Institute for Health and Care Excellence (NICE) has been asked by the Department of Health (DH) to develop a social care guideline on the transition between health and social care. The key focus of the guideline will be on the transition between hospital and home, where someone has social care needs.

This guideline will provide action-oriented recommendations for good practice, aimed at improving outcomes and experiences for users of health and social care services and their families or carers.

The guideline will be based on the best available evidence of effectiveness, including cost effectiveness. It will be relevant to: service users (including people who purchase their own care), carers, communities, health and social care practitioners and providers. It is also relevant to those who plan, procure and organise care and support.

NICE social care guidelines provide recommendations on what works. This may include details on who should carry out interventions and where. However, NICE guidelines do not routinely describe how services are funded or commissioned, unless this has been formally requested by the Department of Health.

This guideline will complement NICE guidelines on a range of topics including the social care guidelines on home care and social care of older people with multiple long-term conditions (in development). For details see section 5 (related NICE guidelines).

3 Need for the guideline

3.1 Key facts and figures

A guideline on transition between health and social care is required because of the negative effects on service users and their families when problems occur during the process. A poor transition creates significant anxiety, leaving people uncertain about their diagnosis and support (Vetter 2003; Kydd 2008 and Ellins 2012). This is particularly true when someone's discharge from hospital to their home is delayed (Auditor General 2003).

The lack of integration between care and support services is one of the factors that causes these delays (Audit Commission 2011). Integrated care and support: our shared commitment, published by the Department of Health in May 2013 and signed by 12 national partners, sets out a framework for how integration can be taken forward at a local level using structures such as health and wellbeing boards.

Poor integration may not be the only reason for delayed hospital discharges, however. Often people are still waiting:

- for their future support needs to be assessed
- for the funding arrangements for their ongoing support to be finalised
- to complete their NHS care (for example, intermediate [bed-based] care)
- for a residential or nursing home place to become available
- for their short or long-term package of home-based care to be finalised
- for community equipment to be supplied
- because they or their family need to decide whether or not they are happy with the services they have been offered, following an assessment of ongoing needs

- owing to disputes between statutory agencies about who is responsible for someone's ongoing support or about an aspect of the discharge decision (NHS England, 2013).

Figures released in September 2013 show that on the last Thursday in August, 1951 patients in acute care settings experienced a delayed discharge, – and most of these incidents were attributed to the NHS.

Another example of a poor transition is the unnecessary transfer of care, such as an avoidable admission to hospital from home, or to residential or nursing care from hospital. Hospital re-admissions are also, arguably, a result of a poor hospital discharge process (McCoy et al. 2007).

Research examining attempts to improve the transition from health to social care focuses mainly on service outcomes: unplanned emergency admissions, emergency bed days and the impact on health and social care resources (Purdy et al. 2012). Where research examines the impact on individuals, it generally focuses on basic functional mobility and mortality (Roderick et al. 2001) and, to a lesser extent, on service user and carer experience.

3.2 Current practice

According to the provisions of the Community Care (Delayed Discharges) Act (CCDDA, 2003), local authorities can be charged by NHS hospitals when someone's delayed discharge is solely attributable to the local authority. In practice, there are important variations about how the provisions of the Act are applied. For example, some local authorities and acute trusts have arranged to pool responsibility for delayed discharge and establish new integrated ways of working.

Guidelines to support transition planning fall into 2 categories: guides describing what people should expect (and are entitled to) in relation to their own discharge from hospital; and guides to raise awareness and improve practice among professionals involved in both discharge processes and cross-sector working.

3.3 Policy

The perception that delayed discharges from hospital were attributable to social care led to the CCDDA in 2003 (Bryan 2010). The Act gave NHS hospitals (in England and Wales) the right to charge the then social services authorities a daily tariff if they failed to provide required social care within 48 hours of a someone being declared medically fit for discharge.

To tackle the related problem of hospital readmissions, in 2011/12 the government introduced financial penalties on NHS hospitals for readmissions occurring within 30 days of hospital discharge (Lansley 2010; Department of Health 2013).

Attempts have also been made to increase the capacity of post-hospital care, for example, by investing in intermediate and other 'step-down' support (bed-based facilities designed to aid the transfer from hospital to home or another setting). More recently, local authorities were given £859 million to improve the hospital/care and support interface (Department of Health 2012).

The following papers relating to transitions and integrated working have been published by the Department of Health or UK Government.

- The Care Bill. House of Lords and House of Commons (2013)
- Integration Transformation Fund. Local Government Association and NHS England (2013)
- Caring for our future: reforming care and support. HM Government (2012)
- Health and Social Care Act. HM Government (2012)
- The Community Care (Delayed Discharges etc) Act (Qualifying Services) (England) Regulations. HM Government (2003):

4 What the guideline will cover

Social care guidelines are developed according to the processes and methods outlined in The social care guidance manual. This scope defines exactly what the guideline will (and will not) examine and what the guideline developers will consider.

The key areas that will be addressed by the guideline are described in the following sections.

4.1 Who is the focus?

4.1.1 Groups that will be covered

All adults (18 and above) who have social care needs and are moving between hospital (or a step down facility) and their home (including care homes).

Protected characteristics under the Equality Act 2010 will be considered within scoping through completion of an equality impact assessment. This will be published alongside the final scope.

4.1.2 Groups that will not be covered

- Anyone under the age of 18. However, the applicability of the recommendations to children will be considered.
- Adults whose care and support is being transferred between settings or services within the same sector. For example, between hospital wards or from home to local authority residential or nursing care.
- Adults moving between health or social care and another sector, for example, the criminal justice system.

4.2 Setting(s)

4.2.1 Settings that will be covered

Health settings

- Inpatient health settings.
- Intermediate care and rehabilitation units in health settings.

Social care and other settings

- Extra care housing (such as warden supported or sheltered accommodation.
- Nursing or residential care homes.
- People’s own homes and other housing, including temporary acoommodation.

- Intermediate care and rehabilitation units in social care settings.

4.2.2 Settings that will not be covered

- Settings in which neither health nor social care is provided.
- Inpatient mental health settings (except for specialist dementia beds in a general or mental health hospital - see section 4.3.2).

4.3 Activities

4.3.1 Key areas that will be covered

All aspects of care planning and provision involved in supporting someone's transition between hospital and their home (including nursing and residential care).

(a) Referral and assessment.

(b) Care planning and review (including discharge planning).

(c) Information for service users in transition and their carers.

(d) Self-directed support (using a personal budget and based on a jointly agreed social care plan).

(e) Communication and information sharing (for example, protocols).

(f) Interventions and services that aid a timely transition to (and prevent unnecessary moves between) health settings and someone's home (including readmission to hospital within 28 days). This might include:

- intermediate care
- short-term care to regain independence (reablement)
- longer-term rehabilitation
- short-term residential placements.

(g) Elements of care packages that may contribute to ensuring a timely transition to (and prevent unnecessary moves between) health settings and someone's home (including readmission to hospital within 28 days). This might include:

- telecare (technology that links people's homes with a monitoring centre that can respond to problems)

- telehealth (the transmission of health-related services and personal health data via the telephone and other telecommunications technologies)
- equipment services
- services provided by the voluntary and community sector, such as befriending or transport services
- advocacy services
- housing services
- therapeutic services including occupational therapy, physiotherapy and nutrition support.

(h) Support for carers of service users in transition between health and social care.

(i) Training, support and supervision of staff working with service users in transition between health and social care.

4.3.2 Areas that will not be covered

- Care planning and provision that does not directly impact on the transition between health and social care.
- Home care, unless it forms part of a care package intended to support a safe and timely transition. Where home care is covered, the focus would be on its availability and organisation to ensure a timely hospital discharge.
- Specialist inpatient and community mental health services. This is because services and arrangements for people in mental health settings are separate and subject to distinctive legislative and policy frameworks. (For example, care following discharge is subject to provisions set out under section 117 of the Mental Health Act. In addition, the Care Programme Approach has to be followed.) However, the experiences of people with mental health problems (including dementia) whose care and support transfers between general hospital and social care will be included. People with dementia whose care and support transfers between a mental health hospital and social care will also be included.

4.4 Main outcomes

The main outcomes that will be considered when searching for and assessing the evidence include:

- user and carer experience, views and satisfaction
- the emotional and psychological impact of transition between health and social care
- quality and continuity of care
- safety and adverse effects of poor transition planning
- social support during transition
- levels of independence achieved by service users
- ability to carry out daily activities
- choice and control for services users and carers
- social care-related quality of life (for example, measured using the Adult Social Care Outcomes Toolkit, ASCOT)
- health-related quality of life
- suicide rates
- life years saved.

Service outcomes include:

- use of health and social care services (community, primary and secondary)
- need for formal care and support
- need for unpaid care and support
- length of hospital stay
- delayed transfers from hospital to home or another social care setting
- admission to residential or nursing care, including inappropriate admissions
- unplanned, inappropriate or emergency hospital admission
- hospital (re)admissions
- emergency department visits.

4.5 Review questions

Review questions guide a systematic review of the literature. They address only the key issues covered in the scope and usually relate to interventions,

service delivery or user and carer experience. Please note these are draft questions, which will be finalised by the Guideline Development Group after consultation on the draft scope.

4.5.1 What are the views of people using services and their carers about the transition between hospital and home (including residential and nursing care)?

4.5.2 What do people using services and their carers think works well, what does not work well, and what could make this transition better?

4.5.3 What are the views of health and social care practitioners about the transition between hospital and home (including residential and nursing care)?

4.5.4 What do health and social care practitioners think works well, what does not work well, and what could make this transition better?

4.5.5 According to research, what are the causes of delayed discharge from hospital?

4.5.6 What is the effect of interventions and approaches designed to improve hospital discharge?

4.5.7 What is the effect of interventions and approaches designed to reduce unplanned or emergency hospital re-admissions within 28 days?

4.5.8 What are the barriers and facilitators to implementing effective transition strategies and practice?

4.5.9 Which adults with social care needs are particularly vulnerable to the impact of a poor transition between hospital and home?

4.5.10 What is the impact of specific interventions to support people with mental health problems during transition between general hospital and home?

4.5.11 What is the impact of specific interventions to support people with end-of-life care needs during transition between general hospital and home?

4.5.12 How much unpaid care is provided by family and friends to support transitions between hospital and home for people with social care needs?

4.5.13 What are the effects of training for health and social care staff on transitions between hospital and home?

4.6 Economic aspects

The guideline developers will take into account cost effectiveness when making recommendations involving a choice between alternative interventions or services. A review of the economic evidence will be undertaken in line with the methods outlined in The social care guideline manual.

The analysis will be informed by evidence on service use, costs and outcomes from a broad range of studies. This may include international evidence. As far as possible, we will use sufficiently long time horizons to ensure we can explore long-term outcomes, such as mortality and nursing home admissions for older people.

The analysis will use a public sector perspective (that is, costs and outcomes from the perspective of the health and social care system). However, a societal perspective will also be adopted to test the sensitivity of the results when including other relevant service user and carer-related costs and outcomes.

4.7 Status of this document

4.7.1 Scope

This is the consultation draft of the scope. The consultation dates are 14 January to 11 February 2014.

4.7.2 Timing

Guideline development will start in March 2014 and the final guideline is scheduled to be published in November 2015.

5 Related NICE guidelines

5.1.1 Published guidelines

- Stroke rehabilitation: long-term rehabilitation after stroke. NICE clinical guideline 162 (2013)
- Patient experience in adult NHS services: improving the experience of care for people using adult NHS services. NICE clinical guideline 138 (2012)
- Improving the experience of care for people using adult NHS mental health services. NICE clinical guideline 136 (2011)
- The management of hip fracture in adults. NICE clinical guideline 124 (2011)
- Rehabilitation after critical illness. NICE clinical guideline 83 (2009)
- Dementia: supporting people with dementia and their carers in health and social care. NICE clinical guideline 42 (2006)
- Improving supportive and palliative care for adults with cancer. NICE cancer service guideline (2004)

5.1.2 Other related NICE guidelines

- Quality standard for supporting people to live well with dementia. NICE quality standard 30 (2013)
- Patient experience in adult NHS services. NICE quality standard 15 (2012).
- Service user experience in adult mental health. NICE quality standard 14 (2011)
- Quality standard for end of life care for adults. NICE quality standard 13 (2011)
- Dementia. NICE quality standard 1 (2010)

5.2 Guidelines under development

NICE is currently developing the following related guidelines (details available from the NICE website):

- Mental wellbeing of older people in care homes NICE quality standard, publication expected December 2013
- Managing medicines in care homes NICE good practice guideline, publication expected February 2014
- Home care: the delivery of personal care and practical support to older people living in their own homes NICE social care guideline, publication expected July 2015
- Social care of older people with complex care needs and multiple long-term conditions (including physical or mental health conditions) NICE social care guideline, publication expected September 2015.
- Excess winter deaths and illness NICE public health guideline, publication expected January 2015.
- Older people: independence and mental wellbeing NICE public health guideline, publication expected September 2015.

5.3 NICE Pathways

- Autism
- Patient experience in adult NHS services
- Service user experience in adult mental health services.
- Rehabilitation after critical illness.
- Dementia

6 Further information

Information on the guideline development process is provided in the 'Social care guidance manual'. Information on the progress of the guideline will also be available on the NICE website.

7 References

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