National Institute for Health and Care Excellence
Transition between inpatient hospital settings and community or care home settings for adults with social care needs

Scope Consultation Table

Date of consultation 14 January – 11 February 2014

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Royal College of Paediatric and Child Health	2	General	We feel that children should not be an add-on (and this reads like an add-on), but should be considered in their own right.	Thank you for your comment. We agree that considering the 'applicability of recommendations to children' may seem as though they are viewed as an 'add on' and may also be rather confusing. We have therefore removed this reference from the scope. To address the gap, NICE have asked the Department of Health and Department for Education to consider the referral of a guideline on transitions between hospital and community or care home settings for children and young people to take account of their specific needs and circumstances.
Royal College of Paediatric and Child Health	3	General	We feel that there will be a need to consider the specific developmental needs of the 18-25 year olds as distinct from older adults.	Thank you for your comment. In adopting a whole adult population focus for this guideline, we recognise that this is not a homogenous group. This will be reflected in our review of the evidence.

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Royal College of Paediatric and Child Health	4	General	There will be a need to specifically consider the specific needs of young people in the 18-19 year olds who are also in transition between paediatric and adult services with reference to prior transition planning which should be in place from early adolescence.	Thank you for your comment. We will consider the needs of adults from 18 years of age when they move between inpatient hospital settings and community or care home settings. However we will not be addressing the transitions they make from paediatric to adult services. This is the focus of a separate NICE social care guideline – Transition from children's to adult services (covering both health and social care)
Royal College of Paediatric and Child Health	5	4.1.2	It states that anyone under the age of 18 is not covered by the guidance but the applicability of the recommendations to children will be considered – this will need further clarification. Furthermore our group would be particularly interested in the plans that NICE have for guidance specifically for the adolescent transitional care which by definition will involve both paediatric and adult health ,social and vocational services.	Thank you for your comment. We agree that considering the 'applicability of recommendations to children' may seem rather confusing. We have therefore removed this reference from the scope and a further guideline referral on childrens transitions between hospital and community or care home settings is under consideration. Transitions between children's to adults' services is the topic of the fourth NICE social care guideline.
Royal College of Paediatric and Child Health	6	General	Vocational transitions will need to be borne in mind with respect to the 18-25 year olds whether that be school, further education etc.).	Thank you for your comment. The remit of this guideline is transition between inpatient hospital settings and community or care home settings for adults with social care

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				needs so education would be considered to be outside the scope.
Royal College of Paediatric and Child Health	7	General	In view of the use of the term transitional care being usually used in both the literature and in current guidance it will be important to clarify this at the outset.	Thank you for your comment. The term 'transitional care' often refers to movement from one health care setting to another and this would not be within the scope of the guideline. We agree that it will be important to be clear that the guideline addresses transitions between inpatient hospital settings and community or care home settings.
Royal College of Paediatric and Child Health	8	4.1.1.	Presumably this guideline is intended mainly to cover the fairly common situation where (typically) frail elderly adults can spend prolonged periods in hospital awaiting a social care funded/provided placement in the community. This would explain why those <18 years of age are excluded (although applicability of recommendations to children will be considered). The discharge of children with neurodisabilities, or other special needs, is sometimes delayed from hospital pending support being arranged in the community from social care. Admittedly, often the community support is provided jointly by social care and health services (whereas this guideline seems to be concerned more with transfer from a health to social care placement). Also, admission to paediatric units of some children with challenging special needs (medical, learning and behavioural), is precipitated by parents or other carers no longer managing to cope at home and, intermittently, this can be due to a lack of social care support (or failure of timely provision of this support).	Thank you for your comment. The remit for this guideline is the whole adult population (18 years and older). As you rightly point out, the effects of poor transitions between health and social care are felt most acutely when delayed transfers of care from hospital occur. We recognise that these problems can also affect children under 18 but during extensive scoping group discussions it was agreed that the scope of the guideline would be more manageable if we excluded children under 18 years. Our view is that a single guideline covering all ages cannot do adequate justice across a wide range of issues nor secure the right stakeholder involvement between health and

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			In view of the importance of co-ordinating health and social care support for certain children and young people to facilitate discharge from hospital and to prevent re-admission to hospital, the scope of this guideline ought to be widened to all cover all ages, although it is accepted that it will more often apply to frail elderly hospitalised adults. Failing this, there should at least be a section in this guideline devoted to < 18 year olds.	social care by children under 18. To address the gap, NICE have asked the Department of Health and Department for Education to consider the referral of a guideline on transitions between hospital and community or care home settings for children and young people to take account of their specific needs and circumstances.
Royal College of Paediatric and Child Health	9	4.3.1.	Hopefully, it will be made clear (in the published guideline), that the areas covered only relate to transition between hospital and home and not the much wider integration of health and social care (and, for children and young people, education), that is necessary for the long term support of those with additional, complex needs.	Thank you for your comment. You are right that the guideline will not address the integration of health and social care in the broadest sense. The remit received from the Department of Health focussed specifically on problems surrounding delayed transfers of care and the prevention of hospital re-admissions. We expect the integration of health and social care to feature as one possible means of improving transitions but we will clarify that integration is not in itself the main focus of this guideline.
Royal College of Paediatric and Child Health	10	4.3.1	The key areas covered include preventing unnecessary transitions between health and community settings. However, it is also important to consider how providing adequate social care and health support in the community may entirely prevent the need to move into a acute health	Thank you for your comment. Preventing re-admissions to general hospital (within 30 days) will be covered by the guideline. Avoiding

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			setting (sometimes recurrently).	hospital admissions will only be covered by the guideline where there is an admission to a step-up facility such as intermediate care where there is no specific emergency need or requirement to be in a general hospital ward, and there is therefore a transition from a social care to health setting. Activities to prevent admissions to hospital which do not specifically involve a transition between settings is a much broader area and will therefore not be in scope. Similarly a transition from health to social care via a step-down facility providing intermediate care is also covered – as that is part of supporting the overall transition. and will prevent readmissions.
Care and Repair England	1	General	Care & Repair England strongly believes that any discussion of transitions from hospital to home must consider housing. A significant issue in housing and ageing is the interface between housing, health and social care. For nearly three decades we have undertaken pilot projects aimed at brokering links between health, social care and housing in order to enable independent living at home for older people. For example In March 2012 we published 'If only I had known – Integration of housing help in a hospital setting' which piloted and evaluated the development of very practical	Thank you for your comment. We agree that the suitability of housing is crucial to ensuring successful, appropriate transitions between inpatient hospital settings and community or care home settings for adults with social care needs, particularly in the sense that someone will be safe from harm and as independent as possible within their home. This is why housing

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			housing options services in hospitals and showed that housing and associated interventions can speed up safe discharge and save money on hospital bed days. Following this, and working with a range of partners including the British Geriatrics Society, Age UK, LGA, Kings Fund, – and supported by DCLG and DH, - a Hospital 2 Home pack is now available to provide practical help and examples to help with the housing aspects of hospital discharge. This was launched in 2012 by Norman Lamb, DH Health Minister and is available on the Housing Learning and Improvement Network website. http://www.housinglin.org.uk/hospital2home_pack/ 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 a consideration and possibly a change to people's housing and living conditions. While the guidance is focused on the transition between health and social care and is particularly focused on hospital to home it cannot ignore people's home circumstances. After all the persons home will be the place/setting in which they receive their social care and support. Decent, appropriate, warm, safe and secure housing has to be seen as a further key ingredient in coordinating the transition between hospital and home. This point was considered at the stakeholder workshop where it was emphasised that successful transitions often meant a move to another setting such as to home or to specialist housing so people's housing needs and the suitability of their home circumstances is a foundation for	services is included as an example of a key area that the guideline will cover. In addition, we have added a reference to the suitability of housing in the 'reasons for the guidance' section of the scope. This will give the issue more prominence and we have also added the useful reference to the 2011 housing strategy for England.

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			a successful transition 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 is a key element in effective hospital discharge. In November 2012, Care and Support Minister, Norman Lamb said: "We recognise that any delay in being able to leave hospital after treatment is distressing for patients and costly to the NHS. People need to be able to return to a home that is safe, warm and meets their needs, and this is particularly important in the case of older people. In order to achieve this health, housing and social care must work in partnership." Some older patients medically ready to leave hospital may not be able to return to their previous home unless adaptations and improvements are made to it or, in some cases, until a new home can be found. Others can return home and manage with equipment, adaptations and temporary measures in the short term, but need more significant alterations to live independently. Either measure can reduce the risk of future health problems. The Select Committee Report (2013) on Public Service and Demographic Change, Ready for Ageing? noted (para 6) 'The split between healthcare and social care is unsustainable and will remain so unless the two are integrated. Sufficient	

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			provision of suitable housing, often with linked support, will be essential to sustain independent living by older people'. In further support of the importance of housing we would advise NICE that •There is a causal link between housing and the main long term conditions (e.g. heart disease, stroke, respiratory, arthritis) whilst risk of falls, a major cause of injury and hospital admission amongst older people, is significantly affected by housing characteristics and the wider built environment. •Poor housing is estimated to cost the NHS at least £600 million per year (BRE and CIEH 2010 Good Housing Leads to Good Health) •Cold housing in particular impacts on demand for NHS services because it; - increases the level of minor illnesses such as colds and flu - exacerbates existing conditions such as arthritis and rheumatism - negatively affects mental health •On average, over each of the last five years, there have been 27,000 excess winter deaths; more than 90% of these deaths occur in the over 60s age group and can be attributed to cold-related illnesses such as heart attacks, strokes and respiratory conditions. The majority of these deaths occurred among those aged 75yrs and over; cold homes a significant causal factor. •Prevention is absolutely crucial to reducing NHS and social care costs. Housing was identified as an important social determinant of health in the Marmot Strategic Review of Health Inequalities and a number of housing related factors are now included in the Public Health Outcomes Framework	

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			for England 2013-16. We believe that, given the evidence, the calls for the greater integration of housing and that the recent Care Act includes housing in its definition of well- being and is referenced in a local council's duty to promote integration, transitions from hospital to home must address people's housing circumstances and options. Local links need to be established to ensure that the home circumstances of those with social care needs are addressed in the transition from on 'setting' to another. We believe that, given these calls for the greater integration of housing and the fact that the recent Care Act includes housing in its definition of well- being and is referenced in a local council's duty to promote integration, transitions from hospital to home need to address people's housing circumstances and options and ensure that local links are established to ensure that the home circumstances of those with social care needs are addressed in the transition from one 'setting' to another.	
Care and Repair England	2	3.1	**Key facts and figures** - it is proposed that the sentence in para 2 which refers to lack of integration between care and support adds 'and other factors such as housing' It should be noted that the Audit Commission report referred to in this section recognises the importance of appropriate housing. Under reasons for delayed hospital discharges add that people are still waiting for 'a housing needs assessment to assess the suitability of the home; 'a move to more	Thank you for your comment. The list of reasons for delayed transfers of care is taken from a particular source (the monthly figures released by NHS England). Issues around housing are not specifically cited in those statistics so they cannot be added at that specific point in the scope. However,

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			appropriate housing such as extra care or sheltered housing'; 'an adaptation to be undertaken in the home'	as explained above, we have added a reference to the suitability of housing in the 'reasons for the guidance' section of the scope, which will give the issue more prominence.
Care and Repair England	3	3.2	**Current practice** – it is unclear why this section does not include specific national guidance on good practice. We would propose making reference here to the Hospital 2 Home pack mentioned in the general section which was supported by the Department of Health. This guide provides clear information for professionals on how housing can be integrated to facilitate better hospital discharge with factsheets, checklists and leaflets which promote and demonstrate good practice. This pack is available on the Housing LIN website. http://www.housinglin.org.uk/hospital2home_pack/	Thank you for your comment. We have not referenced any specific good practice guidance in this section although we will share the information you have provided with the GDG.
Care and Repair England	4	3.3	**Policy –** reference should be made to the Better Care Fund. In particular in relation to housing's role the funding available for Disabled Facilities Grants will in future become part of the Better Care Fund with Health and Well Being Boards expected to sign off Plans for the use of these funds by March 2014. This will be an important driver for integration We also believe that to reflect the role of housing in improving transitions we would add Laying the Foundations – A Housing Strategy for England, HM Government Nov 2011(Section on housing and ageing p48)	Thank you for this information. We have updated the scope and now refer to the Better care Fund as opposed to the Integrated Care Fund.
Care and Repair England	5	4	**What the Guidance will cover** - As the Social Care Guidance Manual includes in scope 'the support the	Thank you for your comment. Housing services are included in the

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			development of inter-agency and inter-professional working' we would propose that this section includes a reference to housing in the paragraph on integrated health and social care for older people. This would fulfil and take forward the expectations of the Care Bill in relation to the role of housing in the integration agenda and would ensure that people's housing needs and aspirations are included in the development of quality transitions between health and social care for people and their carers.	section on 'what the guideline will cover', specifically because of their contribution to ensuring timely transitions. When we refer to housing services in this context we mean support services such as the repairs and adaptations that may be made to ensure someone is safe from harm and as independent as possible within their home.
Care and Repair England	6	4.1.1	**Groups that will be covered** – we suggest that this should include carers	Thank you for your comment. Support provided to carers to facilitate successful transitions is included in the remit of the scope. Outcomes for carers are also included.
Care and Repair England	7	4.2.1	**Settings that will be covered –** we propose amending the first line of 'Social care and other settings' to 'Extra care housing and sheltered/specialist housing'	Thank you for your comment. Under 'social care and other settings' we have amended 'extra care housing (such as warden supported or sheltered accommodation)' to read 'extra care housing (such as warden supported or sheltered/ specialist accommodation)
Care and Repair England	8	4.3.1	**Key areas that will be covered** – under b) amend to 'Care planning and review (including discharge planning and housing assessment)' f) add 'home adaptations and repairs' to the list of interventions and services g) under housing services add '(including home adaptations, repairs, housing advice and information and specialist housing)	Thank you for your suggestions. Assessment refers to assessment of the full range of someone's needs in relation to transitions between inpatient hospital settings and community or care home settings for adults with social care needs.

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				Housing is implied. The services given as examples under 'f' are specifically designed to facilitate timely and successful transitions. We think it is more appropriate to cite housing services under 'g'.
Care and Repair England	9	4.4	**Main outcomes –** add 'suitability of housing'	Thank you for your suggestion. Suitability of housing is very broad, potentially taking us beyond the scope. It may also be useful to note that the outcomes we assess and report on will be subject to those used in included studies.
Care and Repair England	10	4.5	**Review questions –** add ' What are the views of housing practitioners/policy makers and how can they better contribute to coordinated transitions	Thank you for your suggestion. We have changed one of the review questions to include the views of housing practitioners as well as those of health and social care practitioners.
Elcena Jeffers Foundation	1	General	EJF is committed to work with NICE on Health and Social Care	Thank you for your support.
MITIE Healthcare Solutions	1	4.3.1	Appropriate assessment and hand over prior to discharge – multiple experiences nationally of unfit patients being returned home	Thank you for your comment. This is an important point and is likely to be addressed during guideline development.
MITIE Healthcare Solutions	2	4.3.1	Communication to include direct information to home care provider from point of assessment – frequent last minute returns, with very short notice	Thank you for your comment. This is an important point and is likely to be addressed during guideline development.

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MITIE Healthcare Solutions	3	4.3.1	Standards for patient return home – clothing, money or access to, ensuring food is at home etc	Thank you for your comment. This is an important point and is likely to be addressed during guideline development
MITIE Healthcare Solutions	4	General	Access to funding – transition of financial responsibilities. Allowing the same providers to provide care across health and social provision, continuity of care based around the patient rather than the requirements of commissioning arrangements.	Thank you for your comment. These are important points and are likely to be addressed during guideline development.
Leeds City Council	1	Generic	Generally we welcome the scope however consideration needs to be given to what is realistic and appropriate	Thank you. We agree that the scope has to be realistic and manageable and this is why we have had to make some difficult decisions about excluding certain areas.
Leeds City Council	2	4.1.2.	Given the integration agenda and the potential for integrated services the term "setting" requires very careful consideration and clear definition for instance a Hospital and an intermediate care facility both run by the same Hospital Trust or the same provider how would this be covered. Alternatively what would be the situation for an individual transferring between care establishments of the same provider, for example from a low to high dependency unit. Clarification of the term setting is required e.g. same building, same provider.	Thank you for your comment. The settings are provided as examples for where health and social care may be provided and between which someone might move when their support needs change. The important issue is that a transition from the provision of health to social care (or vice versa) has occurred. Transitions within health and transitions within social care are not in scope. Finally, intermediate care is within scope as a step up and step down facility during someone's transition between inpatient hospital settings and community or care

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				home settings for adults with social care needs. In light of the scope consultation, the title of the guideline has been changed to reflect a more specific focus on transition between inpatient hospital settings and community or care home settings. The title now reads "Transition between inpatient hospital settings and community or care home settings for adults with social care needs".
Leeds City Council	3	4.3.1	We note that pharmacy services are not specifically covered and believe that such a remit for the guidance be the planning and implementation of safe and effective pharmacy services to support transitions. It may be that this will be part of the care planning process however given the new guidelines for managing medication in Residential homes it is felt that a definitive link between these would be beneficial	Thank you for your comment. The management and review of medicines is included in 'care planning and review (including discharge planning)'.
Leeds City Council	4	4.3.2	Re Home care we believe the specific reference should be made to a safe, timely and appropriate discharge to home.	The safe and timely transition from inpatient hospital settings to community or care home settings is one of the major areas of concern for this guideline. Home care as a service is included in this guideline in so far as it facilitates that transition. Home care services more broadly are the exclusive focus of another NICE social care guideline Home

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				Care, which is currently under development..
Leeds City Council	5	4.4	One of the outcomes should be effective engagement of services users and carers in planning It is felt that account should be taken of service user desires so the quality of a transition should at least in part be defined by service user and carer perception. Additionally there should be consideration of what is appropriate and realistic for example appropriate and realistic levels of independence are achieved. Additionally there should be some acknowledgement of the role played by appropriate communication and sharing of information. A good high quality care plan is of little use if it is not written appropriately so service users and carers can understand what is being provided if it is not then shared with them.	Thank you for your comments, with which we are in agreement. Service user outcomes are of critical importance. Outcome measures defined from the perspective of people using services and their carers will be prioritised. Information for service users and carers in transition is included as a key area within the scope.
Leeds City Council	6	4.5.	Review questions should include what are the most important factors to service users and carers though this may be covered under 4.5.3	Thank you for your comment. The views of people using services and their carers about what works and what could be improved in transitions will be addressed in the first three review questions.
Leeds City Council	7	4.5.	What works well in engaging service users and carers in the planning of discharges.	Thank you for your suggestion. We expect this important area to be addressed in at least the first four review questions.
Public Health	1	General	We are suggesting these inclusions in the social care guideline (in reference to the first and second points) because	Thank you for your response to the consultation.

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England			we believe that by acknowledging the value of public health interventions, social care commissioners and providers can work together to make sure these are including in care plans both at individual and population level. The third point is suggested in response to your questions relating to the consideration of equality in your scope of work.	
Public Health England	2	3.1	Key facts and figures – add after last paragraph "Services that both address secondary prevention (aimed at reducing the development of risk factors to established disease) and tertiary prevention (aimed at reducing disease progression) should be an important consideration when developing integrated care plans for service users."	Thank you for your suggestion. On the basis of the remit issued by the Department of Health for this guideline, we consider public health to be outside the scope. Therefore, we have not amended the key facts and figures to include your suggested paragraph.
Public Health England	3	3.3	3.3 Policy – add "Health and care integration: making the case from a public health perspective" https://www.gov.uk/government/publications/health-and-care-integration-making-the-case-from-a-public-health-perspective	Thank you for your suggestion. As above, on the basis of the remit issued by the Department of Health, we consider public health to be outside the scope. Therefore, we have not amended the policy section to include your suggested reference.
Public Health England	4	4.3.1	4.3.1 – add the term "Social prescribing" as part of (g) - can be merged with point 5 - Appropriate aids to help the service user understand their care plan e.g. if they are hard of hearing, if they do not understand English well etc.	Thank you for your comment. Social prescribing is likely to be captured under care planning and review. Helping people to understand their care plans will be addressed in 'information for service users in transition' and in certain review

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				questions about service users' experiences. We have not specifically added this to the scope.
Bladder and Bowel Foundation	2	General	This is an area of health and social care that has been lacking for a considerable amount of time. The scoping document highlights that service users commonly feel let down by services during the transition phase. This message is frequently echoed by callers into the Bladder & Bowel Foundation helpline. The document and workshop notes indicate that integration between services will be considered as the key to future success. Teams in Scotland have already demonstrated that effective cross working both inreach and outreach have helped to smooth the transition phase for service users.	Thank you for your comment. We anticipate that integration will be an important aspect of the guideline, in so far as it contributes to safe, timely transitions and the prevention of avoidable admissions to hospital or care homes.
Bladder and Bowel Foundation	3	3.1	Service users commonly report significant unmet needs following a transition of care. Guidance needs to reinforce integration of services putting an emphasis on communication and ownership. Treatment plans should not be interrupted or forgotten during the transition phase - it must be the responsibility of the 'named care giver' on admission to ensure that the planned care is seamless by providing an adequate hand over during the transition phase.	Thank you for your comment. As above, we recognise the contribution that integration can make to improving transitions between inpatient hospital settings and community or care home settings for adults with social care needs.
Bladder and Bowel Foundation	4	3.1	Funding is often the main cause of failure during the transition phase. It is not unusual to hear of a delayed discharge because the equipment required to facilitate the discharge isn't 'in my budget' Integration in its true sense must make allowances for this. Step down teams funded by both health and social care have been effective at ensuring smooth transitional phases in a number of areas.	Thank you for your comment. We recognise that complications and disagreements around funding responsibilities may be found to contribute to problems with transitions. The way that people manage the responsibility for funding will be covered in this guideline since that is an important aspect of

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				transition planning. However it is worth noting that NICE social care guidance does not routinely address financial assessment procedures, eligibility criteria and charging policies so these specific areas will not be included with scope.
Skills for Care	1	General	The document is clear and covers all expected generic areas of transistition. It should also cover housing providers as housing providers have a key role in successful transition. Under mental health will this also examine transition in the context of homelessness? Plus is there enough explicate reference to diversity and the impact of people's culture on transition and workers knowledge and behaviour in relation to dignity. Safeguarding is not explicitly noted. This is also an important area in context of transistion.	Thank you for your comments. We agree that the suitability of housing is crucial to ensuring successful, appropriate transitions between inpatient hospital settings and community or care home settings for adults with social care needs, which is why housing services is included as an example of a key area that the guideline will cover. In addition, we have added a reference to the suitability of housing in the 'reasons for the guidance' section of the scope. This will give the issue more prominence. However it should be noted that we distinguish between the provision of housing support services to enable discharge from hospital (for example) as distinct from Local Authority Housing Needs and Options Services and/or social

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				housing providers. People without a home were identified as part of the equality impact assessment (EIA). The effect of recommendations made in the guideline on groups identified in the EIA will be examined. People with different cultural, religious and LGBT requirements were also identified through the EIA. Adult safeguarding is an important issue and reflecting this, we have added 'safeguarding' as an outcome in the scope.
Skills for Care	2	4.3.1	Should say learning and development, not training	Thank you for your comment. We have changed the wording of 4.3.1 accordingly.
Skills for Care	3	Generic	Specific mention of transition between hospital and home for people with a learning disability would be helpful as this can be a significant issue where transitions can become difficult.	Thank you for your comment. All adults are considered within the population of interest for this guideline. No single condition will be prioritised at the evidence review stage. However, certain groups of adults have been highlighted by the equality impact assessment.
Skills for Care	4	4.4	Safeguarding should be mentioned here.	Thank you for your comment. Adult safeguarding is an important issue and reflecting this, we have added 'safeguarding' as an outcome in the

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				scope.
Skills for Care	5	4.5.13	Should talk about learning and development rather than training.	Thank you for your comment. We have changed the wording of 4.5.13 accordingly.
Skills for Care	6	4.5	There are specific issues related to people with a learning disability that should be picked up here.	Thank you for your comment. Our search strategies will identify research evidence about all adult service user groups, including adults with learning disabilities.
Skills for Care	7	4.5	The impact of transistion on housing providers should also be picked up here.	Thank you for your comment. We consider the impact on housing providers to be outside the scope. However, review question 4.5.3 has been changed to include the views of housing practitioners as well as health and social care practitioners.
Department of Health (DOH)	1	General	I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.	Thank you, this has been noted.
Multiple Sclerosis Trust (MS Trust)	1	General	Not expressly articulated throughout this document is the lack of nursing home and residential care places that are locally provided and appropriate for adults under 65. There is a lot of emphasis on care of the elderly, but a significant number of people of working age will need to access supported living, residential or nursing care. Avoidable admissions: our concern is that most focus has been on avoiding admissions to hospital from home for the elderly, but that investment in community services has been lacking for people of working age. A proportion of disabled people of working age, particularly some of the MS	Thank you for your comments. The population of interest for this guideline is all adults, aged 18 and above. We have made some changes to the scope in an attempt to clarify this. The scope tries to be clear that the focus of the guideline will be on ensuring safe, appropriate transitions from inpatient hospital settings and community or care

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			population, are being routinely admitted to hospital with avoidable symptomatic complications such as UTIs, fractures from falls etc, which are avoidable with better provision of community support. Social care: the guidance assumes that care is available in all areas for those who are able or willing to pay. However, we are aware of areas in the country where there is no well-developed local care economy, so that one of the issues with delayed discharge is a lack of availability of carers to provide home support.	home settings but also on preventing unnecessary transitions such as hospital re-admissions or avoidable admission to nursing and residential care from hospital. The guideline will not make recommendations about the nature of the local care economy. This is because, unless they are specifically described in the remit, NICE social care guidance does not cover how care and support is funded or the mechanisms of commissioning. Shaping and developing the local market is an issue for local authorities.
Multiple Sclerosis Trust (MS Trust)	2	3.1	An additional cause of delayed discharge may be a wait for or lack of appropriate housing, such as a supported housing scheme.	Thank you for your comment. The list of reasons for delayed discharges is taken from a particular source (the monthly figures released by NHS England). Issues around housing are not specifically cited in those statistics so they cannot be added at that specific point in the scope. However, we agree that the suitability of housing is crucial to ensuring successful, appropriate

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				transitions between inpatient hospital settings and community or care home settings for adults with social care needs, which is why housing services is included as an example of a key area that the guideline will cover. In addition, we have added a reference to the suitability of housing in the 'reasons for the guidance' section of the scope.
Multiple Sclerosis Trust (MS Trust)	3	4.3.2	Areas that will not be covered: we are concerned that the guideline will cover people with dementia whose care and support transfers between a mental health hospital and social care, but not people with other conditions, such as MS. In MS, major mental illnesses such as dementia and clinical psychosis are known if rare consequences of their physical condition, which may require enforced inpatient care in a mental health setting. These individuals are likely to have significant physical disabilities and so it is important that the guideline addresses management of their transfer from health to social care.	Thank you for your comment. All adults, including people with dementia and people with MS are considered to be within scope where they are moving between inpatient hospital settings and community or care home settings. We agree that the issue of transitions between acute mental health settings and community or care home settings are critically important. The scoping group has discussed the issue extensively. The group felt that to address transitions from acute mental health settings adequately, the topic should be dealt with separately. Owing to the strength of feeling expressed through the consultation, the Department of Health has confirmed that transitions between inpatient

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				mental health settings and community or care home settings for people with social care needs will be covered in a separate NICE guideline (to be referred).
Royal College of Psychiatrists (RCPSYCH)	1	General	It is highly unsatisfactory that acute mental health and all other mental health wards are excluded from the guidance. Given the very close links that in-patients of mental health wards require with social care, if the system is to work at all effectively and avoid long and inappropriate hospital stays, it is imperative that mental health wards are included in the NICE guidance. Patients who fall under rehabilitation services use around 25% of the total combined health and social care budget annually, accounting for around £1.5 Billion per annum (Mental Health Strategies, 2010). However, they only make up a small proportion, around 10%, of those in secondary mental health services. This guideline only applies to those over 18 year old, although it notes that "consideration will be given to the applicability to under 18 year olds". We suggest that when consideration is given to under 18s, that paediatric, child & adolescent psychiatry and Children's Social Services are involved in this work. I think this will require a significant separate piece of work with experts from Children's services and cannot simply be an 'add on'. The Rehabilitation & Social Psychiatry Faculty would be very willing to provide expert input to the Guideline Development	Thank you for your comment. We agree that the issue of transitions between acute mental health settings and the home are critically important. The scoping group has discussed the issue extensively. The group felt that to address transitions from acute mental health settings adequately, the topic should be dealt with separately. Owing to the strength of feeling expressed through the consultation, the Department of Health has confirmed that transitions between inpatient mental health settings and community or care home settings for people with social care needs will be covered in a separate NICE guideline (to be referred). In recognition of the interrelatedness of mental and physical health, it is envisaged that this guideline and one covering acute mental health settings could be combined in a NICE transitions pathway.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
			Group. The legislation around the Mental Health Act, Section 117 and CPA does not adequately cover the issues and there remains long waits on mental health wards, including rehabilitation wards, because of a disconnect between health and social care. This is likely to be exacerbated by the current financial constraints on both health and social care budgets, unless managed very carefully. This guideline is still necessary to outline best/acceptable practice at a national level, as currently there is much variation nationally and NICE guidance on the matter would strengthen the case to make the best efficient use of total resource across the budgets/services. More importantly, it is likely to assist in the avoidance long hospital stays when they are ready to live once again in the community. This is the antipathy of a recovery approach and any formal guidance that would strengthen the case to aid a smooth transition between health and social care would be key to reducing the national variability. To exclude mental health settings would also not be in line with the current national policy of parity of esteem and we would wish to raise this more formally if necessary. This is mainly about the discharge arrangements for people leaving acute hospitals and needing social care after discharge. Although aware of the legal reasons stated for this in the scope, it is not adequate. There are many people in mental health units who need social care after discharge, including those with dementia, and excluding them is again not consistent with the new legal	Other stakeholders commented that they found our reference to 'considering the applicability of recommendations' to children under 18 years to be unsatisfactory and confusing. In particular, they agreed with your comment that children were simply being treated as an 'add on'. We have therefore removed this reference from the scope. The population of interest for this guideline is adults aged 18 years and older. However, in light of the consultation and to address the gap, NICE has asked the Department of Health and Department for Education to consider the referral of a guideline on transitions between community or care home settings for children and young people to take account of their specific needs and circumstances. This would contribute to a suite of guidelines on the topic of transition between health and social care.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
			requirements for parity of esteem. It also puts unnecessary burden on mental health services with high numbers of delayed discharges and social services always prioritising general units for the stated legal and financial reasons. This review is timely but it would be more helpful to our patients if mental health units and the need for social care on discharge were included.	
Monitor - Independent Regulator of NHS Foundation Trusts	1	1; 1.1; 2; General	**Balancing the focus of this guideline with broader ambitions for more integrated care.** Integrated care – or person-centred coordinated care – is a broad subject that covers a range of health and social care users across multiple sectors, organisations, care professionals, services and specialties along a person's care pathway. We understand that your guidelines focus on the transition between hospital and home, but, in doing so, is clearly narrower in remit. This is not a problem in and of itself; however, you may wish to consider stating upfront and in the title that this guideline does not seek to provide comment on the wider agenda of more coordinated, integrated care and support, but instead focuses on areas where you believe the most impact can be made. These include avoidable admissions, delayed transfers of care, intermediate care and emergency readmissions.	Thank you for your helpful comment. You are right that this guideline will not cover integration in its broadest sense. Integration between health and social care will be included in so far as it is found to facilitate appropriate, timely transitions or prevent unnecessary admissions. In light of yours and similar comments, the decision has been taken to change the title of the guideline to clarify the specific focus on the transition between inpatient hospital settings and community or care home settings for adults with social care needs.
Monitor - Independent Regulator of NHS	2	2	Monitor is currently developing guidance to be considered alongside its provider licence condition on integrated care, which will include illustrative behaviours to better enable and deliver integrated care. This may be of use as you consider	Thank you for this information, which we will share with the GDG.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Foundation Trusts			'action-oriented recommendations for good practice'.	
Monitor - Independent Regulator of NHS Foundation Trusts	3	3.3	Monitor suggests updating certain phrases, e.g. by referring to delayed discharges as delayed transfers of care.	Thank you for this comment. We have amended the language of the scope accordingly.
Monitor - Independent Regulator of NHS Foundation Trusts	4	4.2.2; General	**Suggested addition to scope. Mental health and learning disability** – mental health and learning disability are areas where service users most often need complementary health and social care approaches to care and you may wish to consider including these more within the scope of the guidelines. We consider that mental health provision within the inpatient acute setting should be within scope, not least since evidence shows that patients with mental health conditions and dementia experience longer lengths of stay and often need much more support on discharge. Additionally, liaison psychiatry and dementia consultants in A&E departments play a crucial role in both preventing admissions (through A&E case finding) and facilitating discharges. There is good evidence of cost effectiveness for this service, such as the specialist multi-disciplinary Rapid,	Thank you for your comment. Adults with mental health problems moving between inpatient hospital settings and community or care home settings and adults with learning disabilities are all included within scope. As the guideline will focus on the whole adult population, we would try to avoid specifying particular groups at this stage. Our search strategies will identify existing evidence pertaining to all adult service user groups, including those you mention. Linked with your comment, a number

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			Assessment, Interface and Discharge (RAID) model.	of stakeholders felt strongly that we ought to expand the scope to include transition between acute mental health settings and community or care home settings. We agree that this is an important issue that warrants a separate guideline. The Department of Health has now confirmed that transitions between inpatient mental health settings and community or care home settings for people with social care needs will be covered in a separate NICE guideline (to be referred).
Monitor - Independent Regulator of NHS Foundation Trusts	5	General	**Suggested addition to scope. Commissioners –** integrated care should not be viewed in the context of providers in isolation. The role of (NHS and/or local authority) commissioners, working with local providers, is a vital part of developing and funding better and more integrated patterns of care. Indeed, work on the 'House of Care' sets out an excellent model for coordinated service delivery across the whole system, where responsive commissioning is essential and underpins the involvement of patients and care professionals, care planning and organisational systems and processes.	Thank you for your comment. NICE social care guidelines are aimed at commissioners as well as providers since they play a key part in the development and delivery of high quality services.. However, the guidelines do not cover commissioning procedures, procurement models (such as block contracting or spot purchasing), and contractual arrangements.
Monitor - Independent	6	General	**Suggested addition to scope. Success of hospital**	Thank you for your comment. Hospital re-admissions are within the

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Regulator of NHS Foundation Trusts			**discharge** – while clearly a reduction in delayed transfers of care is beneficial, this should not be considered successful where patients are consequently readmitted within a short period of time because the discharge was poorly considered or rushed. Considering the effectiveness of hospital discharges by also understanding, e.g. the volume and causes of failed discharges or readmissions, may therefore be helpful.	scope of this guideline and therefore will be considered.
Monitor - Independent Regulator of NHS Foundation Trusts	7	General	**Suggested addition to scope. The role of pharmacy and medicines management** – the role of pharmacists is not always included in the context of integration and coordination of care, yet it may be useful to include hospital and community pharmacy in the scope of this guideline. Polypharmacy (or the concurrent use of multiple medications by one individual) is increasingly common and driven by similar factors to the need for more integrated care, i.e. the ageing population and growing prevalence of multi-morbidity. Evidence (such as by the King's Fund) suggests that medicines management plays a large role in both ensuring: timely discharge of patients (take-home prescriptions are often late); and safe and effective discharge (as many readmissions are due to patients experiencing adverse drug interactions or not taking the medicine as prescribed due to a lack of understanding or agreement).	Thank you for your comment. Hospital and community pharmacy would be considered within scope where it supports timely hospital discharge. The management and review of medicines is included in 'care planning and review (including discharge planning)'.
Monitor - Independent Regulator of NHS Foundation	8	General	**Suggested addition to scope. Continuing Care / Continuing Health Care** – you may also wish to consider covering this type of care which is provided to an adult or older person with long-term conditions once they have left hospital, to meet physical or mental health needs arising from disability, accident or illness. It often requires a combination	Thank you for your comment. We recognise that, disputes around NHS Continuing Care may be found to delay transfers of care. The way that people manage the responsibility for funding will be

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Trusts			of health and social care and can be provided in home, care or nursing home settings, where delays are often reported due to disputes over funding responsibility (depending on whether the main need for care relates to health or otherwise).	covered in this guideline since that is an important aspect of transition planning. However it is worth noting that NICE social care guidance does not routinely address financial assessment procedures, eligibility criteria and charging policies so these specific areas will not be included with scope.
Monitor - Independent Regulator of NHS Foundation Trusts	9	General	**Suggested addition to scope. Patient perspective** – ensuring that patients (and their carers) are fully empowered in, and included in all aspects of, their own care are important aspects of improving the coordination of care. The National Voices 'I' statements purposefully set out the experience of integrated care from the individual's own perspective. And they usefully cover areas such as transitions and the importance of understanding their care plan and any medicines they take with them, what to expect and how to keep in contact with previous services and professionals. As part of their Transitions Care Journey approach, for example, Kaiser Permanente ensure that a specialised telephone number (answered 24/7) is included on all discharge instructions for use between discharge and the patient seeing their primary care physician. Including patients and carers within scope, including the recommendations, will help improve an understanding of the experience and frustration around care transfers, reduce anxiety and improve concordance with take-home prescriptions and reduce	Thank you for your comments, with which we are in agreement. Service user experiences and outcomes are of central importance. Outcome measures defined from the perspective of people using services and their carers will be prioritised in the evidence review.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
			readmissions.	
Monitor - Independent Regulator of NHS Foundation Trusts	10	General	**Inconsistency within the scope.** There are also some areas where their exclusion from the scope is not in line with other aspects of the Consultation.	Thank you, we have responded to your points below.
Monitor - Independent Regulator of NHS Foundation Trusts	11	General	**Inconsistency within the scope. Primary and community care** – although service outcomes include the use of primary and community care services, no mention is made for the main body of the guideline of the roles of primary and community care in avoiding hospitalisation, arranging discharges and preventing readmissions. The exclusion of e.g. prevention, early intervention and health maintenance does not fit with the Consultation's focus on tackling avoidable admissions and emergency readmissions. And the guideline should also reflect that reducing delayed transfers of care requires that community, primary, acute and social care bodies work together. Additionally, in order to provide the most appropriate care for patients when they leave hospital to help avoid emergency readmissions within 30 days, planning may include coordinating with the patient's family and GP regarding medication or arranging post-discharge equipment, rehabilitation or reablement with a community or social care provider.	Thank you for your comment. Under 'key areas', the scope does mention the role of community care services in improving transitions. In response to your comment, primary care has been added to the key areas of the scope as an 'element of a care package' where it is coordinated with social care to improve transitions.
Monitor -	12	4.1.2;	**Inconsistency within the scope. Housing** – we are pleased	Thank you for your coment. Housing

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Independent Regulator of NHS Foundation Trusts		4.3.1(g)	to see that housing services are in scope, as the lack of suitable of housing and town planning can lead to exacerbated needs or early and unnecessary institutionalisation. However, this is not in line with the statement that adults moving from health or social care to another sector, such as the criminal justice system, will not be covered by the guideline.	services (e.g. arranging repairs and adaptations) to ensure someone is safe from harm and as independent as possible within their home are included within scope for their contribution to ensuring smooth transitions between inpatient hospital settings and community or care home settings for adults with social care needs. For example, the suitability of someone's housing will be crucial to whether a safe transfer of care can be made from inpatient hospital settings and community or care home settings.
Monitor - Independent Regulator of NHS Foundation Trusts	13	4.3.2; General	**Inconsistency within the scope. Mental health** – there is a potential inconsistency that while mental health is not included more widely, you do intend to include the experience of people with mental health problems whose care and support transfers between general hospital and social care within scope.	Thank you for your comment. Adults with mental health problems moving between inpatient hospital settings and community or care home settings are included within the scope. The scoping group took the difficult decision to exclude (moves to and from) acute mental health settings. It is an important issue and cannot be adequately addressed in a single guideline. Owing to the strength of feeling expressed through the consultation, the Department of Health has confirmed that transitions between inpatient mental health settings and community or care home settings for

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				people with social care needs will be covered in a separate NICE guideline (to be referred).
Monitor - Independent Regulator of NHS Foundation Trusts	14	4.3.1(f) (g); 4.5.7	**Inconsistency within the scope. Emergency readmissions** – the Consultation recognises the importance of timely transitions, including the role of readmission to hospital within 28 days. However, and as set out in the section on policy, the current indicator in both the NHS Outcomes Framework and the 2014/15 National Tariff Payment System is to measure emergency readmissions within 30 days. Any work to review the effect of interventions and approaches designed to reduce unplanned or emergency hospital readmissions should therefore use the most up-to-date indicator.	Thank you for highlighting this. We have changed the wording of the scope to reflect the 30 day indicator.
Monitor - Independent Regulator of NHS Foundation Trusts	15	4.3.1 (e)	There are a number of 'key areas' you have identified that we are particularly pleased to see will be covered by the guidelines. This includes **information-sharing**. Ensuring that the right information is collected and effectively disseminated to the right organisations at the right time can play a critical role in ensuring that care is delivered in an integrated way, but is often regarded as a barrier to more integrated care. This subject is addressed in both *Integrated Care and Support: Our Shared Commitment* and in Monitor's integrated care frequently asked questions on our website. You may also find it helpful to link in with the work that is currently ongoing by the Integrated Care and Support Collaborative partners, largely the Department of Health and NHS England and through the integrated care pioneers programme.	Thank you for these links, which we will share with the GDG.
Monitor -	16	4.4	There are a number of 'key areas' you have identified that we	Thank you.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Independent Regulator of NHS Foundation Trusts			are particularly pleased to see will be covered by the guidelines. This includes **outcomes**. One of the main objectives for more integrated care is to improve the user's experience and care outcomes. We are therefore pleased to see that the measurement of user and carer experience in this area features in the scope, particularly as previous measures have rarely focused on this.	
Monitor - Independent Regulator of NHS Foundation Trusts	17	4.4	You may find it helpful to review the work recently published by the Picker Institute on behalf of the Department of Health, which recommends that integrated care should be measured in a way that combines information from existing national health and social care data sets with feedback directly from patients, service users and carers. However, this is at a relatively early stage and will not be easy to measure. This would align with the intention, as stated in *Integrated Care and Support: Our Shared Commitment*, that NICE should be closely involved in the ongoing measurement work of the Collaborative, particularly in aligning the measures and Quality Standards and involvement in the evaluation of pioneers.	Thank you. As you know, integration will be included for its role in improving transitions between inpatient hospital settings and community or care home settings for adults with social care needs. We will pass on the links and information to the GDG.
Monitor - Independent Regulator of NHS Foundation Trusts	18	4.4	We would also like to draw your attention to the 'I' statements developed as part of our National Voices' integrated care Narrative. These may also form a good basis for the development of person-centred outcome measures.	Thank you. We agree that the 'I' statements may provide a good basis for person centred outcome measures. The outcomes we assess and report on during the evidence review will depend on what has been used in the existing research. Of course, we will prioritise outcome measures defined from the

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				perspective of people using services and their carers.
Monitor - Independent Regulator of NHS Foundation Trusts	19	4.4	The service outcomes you identify include the following areas where Monitor also has an interest and may be able to advise on relevant technical detail. *2014/15 National Tariff Payment System* (Monitor, 2013) sets out two national variations that are designed to incentivise both the sharing of responsibility for managing the care of patients in the most appropriate setting and the prevention of avoidable unplanned hospital stays: • the marginal rate emergency rule; and • reimbursement arrangements for emergency readmissions within 30 days. Both of these rules were introduced to encourage providers and commissioners to better manage emergency admissions through: effective demand management schemes; well-planned discharges; well-organised rehabilitation and support services post discharge; greater involvement of experienced clinicians earlier in the decision-making process; and more collaborative working and better coordination of clinical intervention with community and social care providers. When properly implemented, these should help to create appropriate incentives for whole-system responses to urgent and emergency care planning.	Thank you for this information.
Monitor - Independent Regulator of NHS	20	4.5	We agree that the review questions cover the right areas of interest. However, one addition you may wish to consider is around whether the right (and high quality) information is available to support decision-making by providers when	Thank you for your suggestion. It is intended that this issue will be addressed by the two proposed review questions on practitioner views.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Foundation Trusts			planning, procuring and organising care and support.	
Monitor - Independent Regulator of NHS Foundation Trusts	21	4.5.8	In terms of the literature review around the barriers and enablers to implementing effective transition strategies and practice, you may wish to review Monitor's publication *Enablers and barriers to integrated care and implications for Monitor* (June 2012) as well as *Integrated Care and Support: Our Shared Commitment* and draw on the wider work of the Integrated Care and Support Collaborative. These publications also set out a number of case studies and learning from both national and international experience which may helpfully inform your research.	Thank you for these useful suggestions.
Chartered Society of Physiotherapy (CSP)	1	General	Key to successful integrated care is professionals working together in multi-disciplinary teams or networks, including both generalists and specialists in health and social care. This needs to be reflected throughout the guidance. Recent research shows that this is a key feature of successful coordination of care for older people with complex health and social care needs. One of the case studies for the research is Torbay, where integrated services are provided by a multi-disciplinary team made up of a core group of care coordinators, community nurses, occupational therapists and physiotherapists. (*Providing integrated care for older people with complex needs. Lessons from seven international case studies*. Goodwin et al, The Kings Fund 2014)	Thank you for this information. We have tried to ensure that the scope is clear about integration being included in so far as it contributes to smooth, timely transitions and the prevention of re-admissions.
Chartered Society of	2	General	Self-care is most evident in service models with a multi-disciplinary team. (*Providing integrated care for older people*	Thank you for this information.

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Physiotherapy (CSP)			*with complex needs. Lessons from seven international case studies*. Goodwin et al, The Kings Fund 2014)	
Chartered Society of Physiotherapy (CSP)	3	General	Current emphasis in public policy has been on improved care coordination, and GPs taking on this role. However evidence suggests that for older people with complex health and social care needs GPs may not be best placed to provide the intensity of support that is required. (*Providing integrated care for older people with complex needs. Lessons from seven international case studies*. Goodwin et al, The Kings Fund 2014)	Thank you for your comment. We would also like to draw your attention to the second NICE social care guidance topic on older people with multiple long terms conditions.
Chartered Society of Physiotherapy (CSP)	4	General	The CSP believes the guidance needs a greater focus on better access to rehabilitation services in the community. Currently there are significant gaps in rehabilitation services. For example a survey of clinicians at 24 high volume NHS orthopaedic centres in England and Wales found that no centres surveyed referred patients to outpatient physiotherapy as a routine pathway of care following a hip replacement. (*Physiotherapy provision following discharge after total hip and total knee replacements*. Artz N et al, Musculoskeletal Care 2013; 11 (1): 31-8).	Thank you for your comment. We recognise the critical importance of rehabilitation services in facilitating timely transitions and preventing avoidable admissions. Rehabilitation is specified as a key area in the scope. The role of rehabilitation is likely to be highlighted by the review questions, which explore what works well in transitions.
Chartered Society of Physiotherapy (CSP)	5	General	Improving rehabilitation in the community for musculoskeletal disorders by investing in more physiotherapy and occupational therapy services has been shown to improve outcomes, provide savings over the long term, and significantly reduce the odds of mortality and institutionalisation. (*Rehabilitation in home care is associated with functional improvement and preferred discharge.* Cook et al. Arch Phy Med Rehabil 2013; 94 (6): 1038-47).	Thank you. As explained above, rehabilitation services feature as a key area in the scope and will be examined in the review questions.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Chartered Society of Physiotherapy (CSP)	6	4.1.1	We would suggest guidance should apply to adults for whom health care at home can prevent/delay either admission to hospital or residential care.	Health care at home is included where it is combined with social care to facilitate hospital discharge and prevent re-admissions.
Chartered Society of Physiotherapy (CSP)	7	4.3.1	We suggest a) and b) include having the right health and social care staff on site to assess risk, plan care and prevent readmissions, the importance of multi-disciplinary working, and the therapeutic services who will advise on current level of patient needs/dependency.	Thank you for your suggestion. These are recognised as important issues and are implied in referral and assessment and care planning and review.
Chartered Society of Physiotherapy (CSP)	8	4.3.1	We welcome the fact that physiotherapy is mentioned as a core component of a care package in g). We would also highlight the importance of physiotherapists in assessment and referral which needs to be reflected in the guidance.	Thank you for your comment. We agree that physiotherapists play an important role in assessment and referral.
Chartered Society of Physiotherapy (CSP)	9	4.5.	We suggest the following question '*What tools and training exists to support health and social care practitioners in managing risks*'	Thank you for your suggestion. Given the focus of this question is tools and training, it raises implementation issues. It will therefore be logged and addressed in the implementation and dissemination plan.
Chartered	10	4.5	We suggest the following question '*What service models exist*	Thank you for your suggestion.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Society of Physiotherapy (CSP)			*to support health and social care practitioners in managing risks'*	Given the focus of this question is models for supporting practitioners, it raises implementation issues. It will therefore be logged and addressed in the implementation and dissemination plan.
Chartered Society of Physiotherapy (CSP)	11	4.5	We suggest the following question '*What techniques and service models exist to improve the quality of decision making by health and social care practitioners in assessments of need and risk, referral, case planning and discharge, including adopting a multi-disciplinary approach'*	Thank you for your suggestion. Again, given the focus of this question is models for supporting practitioners, it raises implementation issues. It will therefore be logged and addressed in the implementation and dissemination plan.
Chartered Society of Physiotherapy (CSP)	12	4.5	In the CSP's experience, problems can occur because referrals are made by ward clerks who don't have all the information they need about the patient and don't know what information to pass on; and/or the referrals are received by staff who don't know what questions they should be asking. We suggest the following question '*What communication strategies exist to ensure that referrals provide the right information, at the right time, to the right person?'*	Thank you for your suggestion. The issue of communication and information sharing is a key area in the scope and will therefore be addressed by existing review questions, particularly 4.5.8.
Chartered Society of Physiotherapy (CSP)	13	4.5	Communication between professionals for people with end of life care needs should include what has been told to patients and family/carers, including on prognosis. We suggest the following question *'What strategies are used to ensure good communication between professionals, and between professionals and patients/family/carers to support people with end of life care'*	Thank you for your suggestion. End of life care needs and communication and information sharing are all included within scope. Review questions about what works well in transition (all adults) and interventions to support people with end of life care needs should identify material on the issue you raise.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Chartered Society of Physiotherapy (CSP)	14	4.5	We suggest the following question *'What training is provided to unpaid carers to ensure they have the skills to support transition, particularly for more complex patients'*	Thank you for your suggestion. Given the focus of this question is on training, it raises implementation issues. It will therefore be logged and addressed in the implementation and dissemination plan.
Chartered Society of Physiotherapy (CSP)	15	4.5	We suggest the following question '*What are the effects of training by health care staff to care staff in developing the skills to support transition, particularly for more complex patients'* The CSP has a good practice example of physiotherapists training care support workers in residential care which we would be happy to share. It has not yet been independently evaluated (evaluation expected next year).	Thank you for your suggestion. Evidence relevant to this issue will be identified via the final review question on the effects of training, although the term 'training' has now been replaced with 'learning and development'.
Chartered Society of Physiotherapy (CSP)	16	4.5	Evidence shows that improved early discharge care services, followed by education, phone support and ongoing rapid access to outpatient care is associated with reduced admission rates for COPD patients (*Early discharge care with ongoing follow-up support may reduce hospital readmissions in COPD.* Lawlor M et al)	Thank you for this reference, which we can consider for inclusion in the systematic evidence review.
Chartered Society of Physiotherapy (CSP)	17	4.5	There is also evidence that intensive exercise programmes following hospital discharge for patients with arthritis resulted in better quality of life at lower costs. *(Cost-effectiveness of intensive exercise therapy directly following hospital discharge for people with arthritis: results of a randomized controlled clinical trial. Bulthuis Y et al. Arthritis Rheum 2008; 59 (2); 237-54).* We suggest the following question*. What are the effects on admission rates and quality of life of early discharge care?*	Thank you for this reference, which we can consider for inclusion in the systematic evidence review. With regards to the suggested review question, we anticipate that this will be covered by review question 4.5.6.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Action on Hearing Loss	1	General	Action on Hearing Loss welcomes the opportunity to provide comments on the 'Coordinated transition between health and social care' draft scope. Hearing loss is a long-term condition affecting over 10 million people in the UK – one in six of the population, rising to 71% of over 70 year olds. As our society ages this number is set to grow and by 2031 there will be more than 14.5 million people with hearing loss in the UK. The majority of those affected are older people and many have other long-term conditions such as dementia, depression, sight loss and cardiovascular disease. These conditions cannot be managed effectively, and their health and care needs cannot be fulfilled, unless their hearing loss is also addressed and properly managed. It is imperative that any planning for transitions between health and social care takes account of the needs of this substantial group. People with hearing loss are particularly vulnerable to poor transition between health and social care services due to the communication barriers that can hinder their access to information and communication with staff, their understanding of their condition(s), and their ability to maintain choice and control. Improving the management of hearing loss, the provision of and access to information and cross-referrals, as well as access to services, will reduce the problems with transition between settings, which will save money and allow people with hearing loss to live healthy, independent lives. Our research report 'Joining Up' gives examples of how proper diagnosis and management of hearing loss can reduce or delay the time spent in acute care, and improve the effectiveness of rehabilitation. Amongst British Sign Language (BSL) users, communication	Thank you for your comment. In adopting a whole adult population focus for this guideline, we recognise that this is not a homogenous group. This will be reflected in our review of the evidence. In addition, the equality impact assessment (EIA) identified certain groups who may be particularly vulnerable to poor transitions. These include people with communication difficulties or sensory impairments. Our search strategies will be oriented to seek out material on these and other groups identified in the EIA.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
			difficulties and barriers accessing and transitioning between health and social care are particularly prominent. BSL users need culturally sensitive provision of care and particular interventions and transition planning to ensure they can communicate independently and are not excluded or neglected during the transition between care services. These include the proper provision of communication support such as BSL interpreters, and access to specialist diagnostic and management tools – interventions that are not usually available in mainstream care but which are essential for this group. As the largest UK charity working for people with hearing loss and deafness, including researching, campaigning and providing services, Action on Hearing Loss would like to offer our expertise and support in developing this social care guidance, in order to improve standards for people with hearing loss and other conditions across the UK.	
Action on Hearing Loss	2	3.1	There is a strong need for this guideline for the large number of people affected by all levels of hearing loss. In many cases poor integration between health and social care services has a negative impact on people with hearing loss, reducing their independence and challenging their ability to manage their hearing loss and other health conditions. *Need for the guideline for people who wear hearing aids* Four out of five people, when fitted with a hearing aid, receive no information about other services, equipment or assistive	Thank you for your comment and for the information provided. As explained above, our search strategies will be specifically oriented to identify material about the experiences of people with hearing loss during transition between inpatient hospital settings and community or care home settings. Within the context of the scope however, we have tried not to single out people with particular needs,

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
			technology, which can help to maximise independence and wellbeing[1]. Those who are referred to social services often experience long delays before receiving an assessment or the community equipment that they need to continue living safely and independently in their homes. Equipment such as flashing smoke alarms can greatly improve the safety and security of someone with hearing loss living independently. Our 2012 'Cut Off' research found that the provision of information that could ensure a successful transition from a hospital setting to receiving care at home is increasingly under threat[2]. Due to reduced budgets, NHS Trusts in England are reducing follow up appointments for first time hearing aid wearers, which minimises opportunities for patients to clarify techniques for managing their condition and learn about and access other support services. Consequently, the patient's ability to manage their hearing loss alongside other health conditions is likely to be reduced. There must be better integration between health and social care services to ensure that people who are newly diagnosed with hearing loss are supported to manage their condition effectively. *Need for the guideline for people who use British Sign Language (BSL)* Particular attention must be paid to ensure that people who are profoundly deaf and use BSL are communicated with	since we are concerned with all adults.

[1] RNID: 'Annual Survey Report 2008', p3.
[2] Action on Hearing Loss: 'Cut Off' 2012, p8. Available at: www.actiononhearingloss.org.uk/cutoff

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
			effectively to enable proper provision of health and care, better understanding and independence among this group, and ultimately successful transition between settings. Currently, communication practice is often substandard and qualified BSL interpreters are not booked for patients who request them. For example, our research report 'Access All Areas' (2012) found that 41% of people who used BSL had left a health appointment feeling confused about their medical condition because they could not understand the sign language interpreter.[3] Ensuring that people with hearing loss who have used healthcare understand how to manage their condition, how to use medication, and what other support is available will improve quality of life, increase their ability to live independently, and reduce rates of admission (and re-admission) to hospital and other problems that can occur while transitioning between health and social care.	
Action on Hearing Loss	3	4.1.1	The guidance should cover the needs of people with hearing loss, who account for one-sixth of the population. The guidance should apply both when people with hearing loss access care in relation to their hearing impairment and when they access care due to another condition that they experience alongside their hearing loss.	Thank you for your suggestion. Adults with hearing loss are included in the reference to 'all adults (18 and above)'.
	4	4.3.1 (a)	People with hearing loss have specific communication needs that should be taken into account during all aspects of care planning and provision. Making the referral and assessment	Thank you for your comment. Our search strategies will identify available evidence about the

[3] Action on Hearing Loss: 'Access All Areas' 2012, p4. Available at: www.actiononhearingloss.org.uk/accessallareas

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			stages accessible and inclusive is a crucial element in successful transition. According to our 'Life Support' research (2013) on local authorities' provision of social care in England and Wales, when a service user needs information or an assessment, in the majority of cases the service is delivered by an underqualified interpreter[4] or even a friend or family member.[5] Better processes must be introduced to book proper communication support where it is needed.	communication needs of people with hearing loss during the referral and assessment stages.
Action on Hearing Loss	5	4.3.1 (b)	Care planning and review should take into account the needs of the large number of people with hearing loss. A variety of methods (email, telephone, textphone and in person) should be offered to enable people with hearing loss to book care planning and review appointments, and then appropriate communication support should be booked to allow individuals to participate in the planning and review discussions.	Thank you for your comment. Our search strategies will identify available evidence about the communication needs of people with hearing loss during the care planning and review stages.
Action on Hearing Loss	6	4.3.1 (c)	At present, information is often not provided in an accessible format. Our 'Life Support' research found that a quarter of local authorities in England and three quarters of respondents in Wales do not offer a bespoke telephone or textphone number for people with hearing loss. This means people with hearing loss may face difficulties finding out about services that are available.	Thank you for this information, which we will share with the GDG.
Action on	7	4.3.1(e)	It is important that health and social care professionals record and share information about the needs of people with hearing	Thank you for this information, which we will share with the GDG.

[4] In order to provide communication support for health or social care appointments a level 6 BSL interpreter is required.
[5] Action on Hearing Loss: 'Life Support' 2013, p5. Available at: www.actiononhearingloss.org.uk/accessallareas

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Hearing Loss			loss when they are referred to other services. Patients' hearing loss and preferred communication methods should be indicated on patient records.	
Action on Hearing Loss	8	4.3.1 (g)	Care packages for people with hearing loss must take account of their communication needs as well as any other conditions. For example, methods such as in many cases, telecare and telehealth packages may need to be adjusted to take account of a person's hearing loss, and alternatives may need to be considered.	Thank you. Our search strategies will identify available evidence about the implications for developing suitable care packages when people have particular communication needs.
Action on Hearing Loss	9	4.3.1 (g)	Services provided by the voluntary and community sector can play a crucial role in ensuring that people with hearing loss have a successful transition, for example many people access rehabilitation and support services which enable them to adjust to their hearing aids following their audiology appointments.	Thank you for your comment. We recognise the important role played by the voluntary and community sector in supporting transitions.
Action on Hearing Loss	10	4.3.1 (g)	Since such a large proportion of service users will have hearing loss, training of staff should include deaf awareness training, to ensure that staff are able to recognise hearing loss, effectively communicate with people with hearing loss, are aware of their right to communication support, and can take steps to improve access for people with hearing loss.	Thank you for your comment. We recognise the importance of staff training and development to support successful transitions. This is reflected both in the proposed review question 4.5.13.
Action on Hearing Loss	11	4.3.2	There is strong evidence of a link between hearing loss and dementia; people with mild hearing loss have nearly twice the chance of going on to develop dementia as people without any hearing loss. The risk increases to fivefold for those with severe hearing loss[6].	Thank you for this information, which we will share with the GDG.

[6] Lin, FR et al.: 'Hearing loss and incident dementia' 2011, *Archives of Neurology 68(2)* pp.214-220.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
			This means that many people with dementia are also likely to have hearing loss, which may be diagnosed or undiagnosed. It is therefore important that all services for people with dementia are accessible to people with hearing loss.	
Action on Hearing Loss	12	4.5.9.	It is important to consider groups of adults that are particularly vulnerable to the impact of a poor transition between hospital and home. People with hearing loss should be considered in this category.	Thank you, we agree that it is important to consider adults who are particularly vulnerable to poor transitions.
Action on Hearing Loss	13	4.6.	There are tangible economic benefits of improved co-ordination between services. Our recently released evidence-based report 'Joining Up' (2013) showed how large cost savings and improvements to quality of life could be achieved from better provision and integration of health and social care services for people who have hearing loss and also have other long-term conditions. For example savings of over £28 million could be achieved in England by taking account of hearing loss in the care for people with dementia[7]. This figure is calculated by offsetting the cost of community-based provision for people with severe dementia and hearing loss against the cost of residential care.	Thank you for this information, which we will share with our economist.
Parkinson's UK	1	**General**	**Summary -** NHS continuing care must be explicitly referenced in the guidelines. An action-oriented recommendation which would ultimately improve outcomes and experiences for service users and/or their families and carers regarding this would be: • to ensure a discussion about NHS continuing care	Thank you for your suggestions, which we will share with the GDG, although we cannot pre determine the recommendations that they might make during the guideline development process.

[7] Action on Hearing Loss: 'Joining Up' 2013, p3. Available at www.actiononhearingloss.org.uk/joiningup)

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			was included in all pre and post-discharge plans, which incorporated a person's family and/or carer, so that those who may need ongoing support after leaving hospital are aware of the funding. As part of the social care guideline scope Parkinson's UK would like to draw your attention to the issue of NHS continuing care. This is where the boundary between health and social care is often mostly heavily disputed and where people find it really difficult to access the care and support they need. NHS continuing care must be explicitly referenced in the guidelines because of the negative effects on service users, carers and families when problems occur in applying for this care funding package in the transition between health and social care - particularly after a person has been discharged from hospital. This is causing significant anxiety and leaves people uncertain about their support (All Party Parliamentary Group (APPG) on Parkinson's: *Failing to Care: NHS Continuing Care in England*, 2013). In the wake of growing concerns that NHS continuing care was not fit-for-purpose, Parkinson's UK, alongside the APPG on Parkinson's, conducted the first-ever Inquiry into the ailing system. Key challenges the APPG found about NHS continuing care, appropriate to the scope of this guidance, include: • The lack of information and advice for the public on how to access this funding package • The process being complicated, protracted and stressful. Delays are common and the appeals process can take months, or even years. It is not unknown for claimants to have died before resolution.	We recognise that disputes around NHS Continuing Care may be found to delay transfers of care. The way that people manage the responsibility for funding will be covered in this guideline since that is an important aspect of transition planning. However it is worth noting that NICE social care guidance does not routinely address financial assessment procedures, eligibility criteria and charging policies so these specific areas will not be included with scope.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
			• Families are often excluded from the process and misinformation on how serious your needs should be before qualifying, particularly prior to discharge – we have even been told of professionals informing families the person needs "to be practically dead" to qualify for NHS continuing care. As identified in APPG report, the process for applying for NHS continuing care is extremely complex and takes a long time. It is clear, however, that this is exacerbated by delays within the process, resulting in individuals waiting for assessments. This can mean delays in hospital discharge or people having to pay for the costs of care in the meantime. Many of the submissions to the APPG made reference to being told of delays and backlogs within the system. Although NHS continuing care is a package of funding, it does affect the fluidity of hospital discharge and exerts huge mental and financial pressure on carers and families who are going through the application process. Two separate respondents to the Failing to Care Inquiry said the following: "The question of how organisations interrelate has been an issue throughout this whole process – and it is very difficult for patients, or their relatives, to know what they are entitled to and who is responsible for providing it." "I learnt, after my mother was discharged, that social services have a joint responsibility with the NHS for safe discharge and should have carried out a community care assessment. If they had done, it might have identified that the provision of physiotherapy was appropriate, as well as perhaps helping to establish a more accurate picture as to whether my mother's needs were actually greater than social services are allowed	

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			to provide." An action-oriented recommendation which would ultimately improve outcomes and experiences for service users and/or their families and carers regarding this would be: • to ensure a discussion about NHS continuing care was included in all pre and post-discharge plans, which incorporated a person's family and/or carer, so that those who may need ongoing support after leaving hospital are aware of the funding. When the Care Bill was being debated in the Lords before the 2013 summer recess, amendments were tabled to do more to promote the existence of NHS continuing care. The Care and Support Alliance called for this and for NHS continuing care to be specifically included in the information and advice service that local authorities give, in order to ensure awareness of and signposting to the system. These amendments were supported by Parkinson's UK and the Alzheimer's Society as members of the Alliance.	
Parkinson's UK	2	**General**	Related to NHS continuing care assessment and funding prior to discharge, it is also not clear from the scope whether the guidance will cover information and guidance that relates to the funding of care if the person's case falls under social care support. In our experience these sorts of queries can also lead to delays in discharge, as a person may not be in a position or even aware that they may need to put in place self-funded arrangements if they are not entitled to a means tested council funded care package, or there may already be some dispute or confusion emerging over the level of care to be funded and its cost.	Thank you for your comments. Information for service users in transition is a key area within the scope. This includes communication and information to and with people using and being assessed for care and support during or to prevent transitions between inpatient hospital settings and community or care home settings. We recognise the importance of

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			We would also like the guidance to cover choice more comprehensively; this is not simply a case of self-directed support and making available personal budgets but at the time of discharge, appropriate placements and choice of location that should be on offer to the individual. All too often we hear of cases where families or individuals feel "railroaded" into agreeing a discharge plan, or being told that suitable social care support is not available at home or locally, and it is not unknown for individuals to be discharged into residential or nursing care many miles from their home, causing distress for them and impacting on family carers availability to visit. The guidance should therefore cover social care commissioners and their duty to plan and shape appropriate support in their local markets. Finally it seems the guidance is not covering good practice in redress and complaints and we would question why as the guidance should look at the user experience from both initial assessment to the availability of redress if transition has been poorly handled.	choice and control and expect these issues to be explored in detail by review questions about people's views and experiences and questions about what works well in transitions. With regards to commissioners, this is one of the audiences for the guideline. However it is important to note that NICE social care guidance does not routinely cover commissioning procedures, procurement models (such as block contracting or spot purchasing) and contractual arrangements. Thank you for highlighting the issue of complaints. We anticipate that this will be covered in the review questions about service user and carer views and experiences. However, the arrangements in place for making complaints about health and social care support are not within the remit of NICE social care guidelines.
College of Occupational Therapists	1	**General**	The College of Occupational Therapists welcomes this draft scope focusing on the transition between health and social care. Guidance in this area is essential in order to help facilitate a coordinated and integrated approach across the two sectors.	Thank you for your support.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
(COT)				
College of Occupational Therapists (COT)	2	**4.3 Activities** 4.3.1 a and f.	Comment: As part of the transition from hospital to a community setting an occupational therapist will complete a functional assessment. They may feel a pre-discharge home visit is indicated. For example, indications for an older person include: • Reasons for admission – i.e. if there is evidence of neglect, and risk factors (as listed below) • Risk assessment indicates a history of self neglect, harm to self or others (for example: fire, gas leaks or flooding) or falls, behavioural and psychological symptoms of dementia, general vulnerability (letting strangers in, security issues) • Absence of carer/relatives who can provide accurate information/ provide support • Nutritional concerns – including adequate diet, fluids, consuming out of date food, etc. • Medication non compliance • Difficulties with ADL's, including transfers and mobility. Home visits are costly and labour intensive but might be key to indicating the most appropriate package of care and support on discharge from hospital. There are marked variations nationally for people receiving a pre-discharge home visit as Drummond et al's (2012) review of stroke services concludes. There is a body of evidence to support home assessments but there is a need to review optimal timing, criteria for assessment, therapist's rationale and the person and carer perspectives (Welch and Lowes, 2005).	Thank you for your comment. This is useful information, which we will share with the GDG. We recognise the importance of a comprehensive assessment process including home visits. The issue will be explored in review questions about service user and carer experiences of transition between inpatient hospital settings and community or care home settings and practitioner views about what works well and how the transition could be improved.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
			References : • Drummond A, Whitehead P, Fellows K, Edwards C, Sprigg N (2012) Occupational therapy pre-discharge home visits for patients with a stroke: what is national practice? *British Journal of Occupational Therapy, 75(9),* 396-402. • Welch A, Lowes S (2005) Home assessment visits within the acute setting: a discussion and literature review. *British Journal of Occupational Therapy, 68(4),* 158-164.	
College of Occupational Therapists (COT)	3	**4.5 Review Questions** 4.5.2 and 4.5.3	Within this section: to seek the view of people and their family and health and social care practitioners on what aspects of discharge planning aided the transition, in particular was a home visit indicated and if so the value of this.	Thank you for your comment. The review questions are intended to be used to investigate a broad range of evidence and so avoid citing particular aspects over others. Positive aspects of discharge planning, from the perspective of people using services, will be captured in 4.5.1 and 4.5.2.
Royal College of Nursing (RCN)	1	General	The Royal College of Nursing welcomes the proposals to develop this guideline.	Thank you for your support.
Royal College of Nursing (RCN)	2	3.3	Does not include reference to the Winterbourne Inquiry or Francis recommendations. The recommendations in both documents will inform development of this guidance.	Thank you for your comment. We agree that these are both important documents which will inform the guidance. The scope has not been changed as the list of policy documents is intended to provide

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				examples rather than be comprehensive.
Royal College of Nursing (RCN)	3	4	It is important to recognise that for people who have a learning disability the interface between health and social care is critical. We know that most people are supported in a community setting and that Learning Disability nurses can bridge the gaps between hospital, social care support, independent sector and other agencies. The following articles highlight good practice: Slevin, E., Truesdale-Kennedy, M., McConkey, R., Barr, O., and Taggart, L. (2008), Community learning disability teams: developments, composition and good practice: A review of the literature. Journal of Intellectual Disabilities. Volume 12, Issue 1, pages 59–79, Sage Publications http://jid.sagepub.com/content/12/1/59 accessed January 2014 Slevin, E., McConkey, R., Truesdale-Kennedy, M., Barr, O., and Taggart, L., (2007) Community learning disability teams: Perceived effectiveness, multidisciplinary working and service user satisfaction. Journal of Intellectual Disabilities volume 11, Issue 4, pages 329 – 342, Sage Publications http://jid.sagepub.com/content/11/4/329.full.pdf+html accessed January 2014	Thank you for your comments and useful information. Adults with learning disabilities are included within the population of interest, and identified in the Equality Impact Assessment (published with the scope). Our search strategies will be oriented to seek out material on these and other groups identified in the EIA and the GDG will be asked to consider the impact of recommendations on those groups.
Royal College of Nursing (RCN)	4	4.1.1	We noticed that the guidance development only concerns over 18 years old adult BUT transition from childhood to adult care services continues to be a really difficult (but important) area that needs more consideration.	Thank you for your comment. We acknowledge the difficulties faced by young people during the transition to adult services, although the issue is not within the scope of this guideline.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
			It would be helpful to clarify in this document if and what guidance is being developed for transition from childhood to adult care services. There is a strong need for pooling of budgets to address people's needs across health and social care divide.	It is however the fourth NICE social care guideline topic: 'Transition from children's to adults' services'. Details can be found on the NICE website.
Royal College of Nursing (RCN)	5	4.1.2	We note that criminal justice settings are out of the scope. This appears to be a missed opportunity! Liaison and diversion between health and social care are crucial to realise the ambition of NHS England into effective Learning and Development models, leading to smoother services (without the 'lumps'). It would be helpful to know if this will be covered under a separate guideline.	Thank you for your comment. Although an important issue, criminal justice settings are outside the remit of NICE social care guidelines and therefore will not be covered.
Royal College of Nursing (RCN)	6	4.3.21 b)	Care planning and review (including discharge planning) should include the patient and their family / carers.	Thank you for your comment. We recognise the critical importance of involving patients, carers and families in order to ensure effective transitions - this is reflected in the scope's key areas, outcomes and review questions.
Royal College of Nursing (RCN)	7	4.3.1. c)	Information for service users in transition and their carers : Information giving should be top of the list and specific attention should also be given to seeking information from the individual and their family /carers.	Thank you for your comment. The list of key areas is not presented in order of importance and we agree that information sharing between services and the people that use those services is a key area of

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				concern. The issue is included within scope.
Royal College of Nursing (RCN)	8	4.3.1 e)	Communication and information sharing: Anecdotally we are aware of instances where inaccurate information has been given to social care services leading to care packages falling through as soon as a relative was discharged, we would like to see an emphasis on timely and accurate information.	Thank you for your comment. This issue is included within scope.
Royal College of Nursing (RCN)	9	4.3.2	We note that home care will not be covered in this guidance unless it forms part of a care package intended to form part of safe and timely transition... Surely the provision of homecare is integral to many discharges?	Thank you for your comment. Home care as a service is included in this guideline in so far as it facilitates successful transitions. Home care services more broadly are the exclusive focus of another NICE social care guideline Home Care (in development).
Royal College of Nursing (RCN)	10	4.3.2	We note that specialist inpatient and community mental health services are excluded. Does the exclusion of these not give rise to the potential for care in a community setting to fail through lack of coordination? Separation of physical and mental health services is not helpful since they are often interdependent.	Thank you for your comment. We agree that the issue of transitions between acute mental health settings and community or care home settings are critically important. The scoping group has discussed the issue extensively. The group felt that to address transitions from acute mental health settings adequately, the topic should be dealt with separately. In light of this, the Department of Health has now confirmed that transitions between inpatient mental health settings and community or care home settings for

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				people with social care needs will be covered in a separate NICE guideline (to be referred). Recognising the interrelatedness of mental and physical health, it is envisaged that this guideline (focussing on inpatient hospital settings and community or care home settings) and one covering acute mental health settings could be combined in a NICE 'transitions pathway'.
Royal College of Nursing (RCN)	11	4.4	Main outcomes:- levels of independence achieved by service user How is independence being defined here? Does it mean 'doing things for themselves' or having control over their daily lives (which may require significant levels of support)	Thank you for your comment. We recognise that independence is a relative concept and should be defined from the service user perspective. It is worth noting that the outcomes we assess and report on are subject to those identified in the included research evidence.
Royal College of Nursing (RCN)	12	4.5	There does not seem to be any question about what people's experiences are? The questions only refer to people's views. It is important to include this as people's experiences will capture people good practice and where there are gaps and/or areas for improvement.	Thank you for your comment. People's experiences were meant to be implied in the questions on user and carer views. However, we have altered the wording of those questions to make it clearer.
Royal College of Nursing	13	4.5	We note that the guideline developers will consider views of patients and service users in the consultations but it has not been made clear within this section if they intend to include	Thank you for your comment. We can confirm we will be looking for evidence which considers the views

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
(RCN)			the view of family/carers, as some patients will be unable to communicate their views due to mental capacity or disability?	of families and carers as we understand the vital and important role they can play in transitions.
Royal College of Nursing (RCN)	14	4.5.10	Impact of specific interventions to support people with mental health problems during transition..: What about people with learning disabilities given the number of official reports concerning failures in care?	Thank you for your comment. Adults with learning disabilities are included within scope. As the guideline will focus on the whole adult population, we would try to avoid specifying particular groups at this stage. Our search strategies will identify existing evidence pertaining to all adult service user groups, including adults with learning disabilities.
Royal College of Nursing (RCN)	15	Equality impact assessment document		
Royal College of Nursing (RCN)	16	page 2	Add care leavers to criteria	Thank you for your comment. This section of the EIA is part of an agreed NICE template and would only be updated to reflect changes to the protected characteristics enshrined in the Equality Act 2010.
Royal College of Nursing (RCN)	17	page 4	Add young people who lack mental capacity	Thank you for your comment – the scope has been changed to reflect the all adult population of interest.
Standing Commission on	1	e.g. 3.4.6	General comment (as a former Commissioner with the Disability Rights Commission and a former Disability Equality Adviser), I note that equality issues and delivery do not relate	Thank you for your detailed response, which we will share with the GDG.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Carers			to treating everybody the same. Commissioners and providers (in the NHS and in social care and elsewhere should be aware that good personalised assessment, with a strong focus on patient and carer experience) will identity issues around age, gender etc. and should help address them appropriately. Many people are at potential risk of discrimination or less favourable treatment because they have multiple factors (eg a LGBT man with a disability from a BME community may be more disadvantaged by his LGBT status than by his ethnic origin, cultural preferences and disability. A disabled woman may experience less equality in treatment because of her gender or her age rather than her disability). An LGBT man may worry that his intermediate care in a nursing home may be less good because of attitudes to his sexual orientation. When thinking about transitions, it will be vital to have regard to the beliefs, background and status of the individual and his or her family. There should be no blanket assumptions (eg that the family can provide total care for an elderly relative coming out of hospital after a major life event like a stroke. That person may have strong views about a wife or daughter providing certain sorts of care (where the right equipment might remove the need for such intimate care anyway). If the relatives are elderly, disabled or have their own other family responsibilities, then the **carer** may be discriminated against in their own right. **It is important to remember that carers have a special status under equalities legislation. They can experience *associative discrimination* by nature of their relationship**	Our equality impact assessment (EIA) identified groups of adults who may be particularly vulnerable to poor transitions including people with protected characteristics under the Equality Act 2010. Our search strategies will be oriented to seek out material on these groups and the GDG will be asked to consider the impact of recommendations on each one. We recognise the crucial importance of family carers and the need to consider their ability and willingness to provide care and the support needs they may have to help them in this role. Carer outcomes, experiences and views are all included within the scope of this guideline. Related to this, we recognise the importance of ensuring someone is transferred from hospital in circumstances (and at points in time) where all necessary care and support – including that provided by and with family members – is available.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
			to a person within the protected categories. Therefore, carers should also be asked – and given sufficient information and advice to understand the implications of the question – WHAT support they can give, WHAT assistance they might need to support their caring role and WHETHER they themselves have health or other problems which will impact on their caring role. **We note that many early returns to hospital after discharge reflect inadequate attention to the ability of the carer to provide the level of care needed without a prper assessment and consideration given to what will enable the patient to return home and stay there. Good reablement packages can help but weekend unplanned discharges may lead to carer breakdown and readmissions.** We can provide a number of case studies if required. Good discharge planning benefits everyone and we would like to see encouragement to hospitals NOT to discharge patients. after 7.00pm in the evening (when it will be impossible for the family to get any extra help) unless there has been a proper planning conversation with the family.	
Standing Commission on Carers	2		We support the idea of all providers/commissioners carrying out **equality impact assessments** to ensure that they are aware of potentially challenging situations when they may inadvertently discriminate against a person or family. These should in turn be linked to robust **equality action plans** setting out areas for improvement and actions to address issues identified in the equality impact assessment. We do not see either assessments or impact assessments	Thank you for your comment, which we will share with the GDG. We are in agreement about the important role of people using services and their carers in the process of improving services. The development of all NICE social care guidance involves service user and carer representatives as well as

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			are only about poor practice but rather as an opportunity to identify what is going well as well as where improvements need to be made. We strongly recommend that **relevant patient/carer and community groups** are involved in this process. We have welcomed a range of local initiatives where members of local community groups, carers and other local third sector organisations have become involved both in the wards and post-discharge to help patients manage the process and have sympathetic and informed support. Many community, faith and carer and other organisations are very willing to provide this support and thereby also make relevant links with the hospital and community services around particular equality issues.	professionals from a range of backgrounds, including the voluntary sector.
Standing Commission on Carers	3		We see local **Healthwatches** and **Health and Well-Being Boards** as having a valuable scrutiny and advice role about equality particular issues in their locality.	Thank you for your comment.
Standing Commission on Carers	4	Section 4.1.2	**We see no reason why children should be excluded**. They experience double transitions (eg from children's to adult services) as well as between health and social care.	Thank you for your comment. Transitions from children's to adults' services are outside the scope of this guideline. However, this is the subject of the fourth NICE social care guideline topic, details of which can be found on the NICE website. We recognise that children and young people do also experience poor transitions between in-patient hospital and community or care

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				home settings and this has been the subject of extensive scoping group discussions. However, the group agreed that the scope of the guideline would be more manageable if we excluded children under 18 years. Our view is that a single guideline covering all ages cannot do adequate justice across a wide range of issues nor secure the right stakeholder involvement. In light of this NICE has asked the Department of Health and Department for Education to consider the referral of a guideline on transitions between in-patient hospital and community or care home settings for children and young people to take account of their specific needs and circumstances.
Standing Commission on Carers	5	Section 4,1,2	We consider that **residential colleges** should be added to the list of settings. Many young adults with a range of disabilities attend these colleges, which are almost invariably residential. .	Thank you for your comment, which was discussed by the scoping group. It was agreed that residential colleges, as a setting, would be a better fit with a guideline on either transitions between children's and adults' services (currently under development) or a separate guideline on transitions between in-patient hospital and community or care home settings focussing on children and young people under 18

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				years. As noted above, NICE has asked the Department of Health and Department for Education to consider the referral of a guideline on transitions between in-patient hospital and community or care home settings for children and young people. Residential colleges have therefore not been added to 'settings' within this scope since they would be covered in a separate transitions quideline on children and young people.
Standing Commission on Carers	6	Section 4.2.2	We have cited residential educational colleges for inclusion. Although this section specifies health or social care only, these colleges also provide health or social care and many students in effect live in them for several years..	Thank you for your comment – as explained above, residential colleges have not been added to this scope.
Standing Commission on Carers	7	Section 4.3.1	We assume that **personal bud**gets will include personal health budgets as well as personal budgets for care and support.	Thank you for your comment. We can confirm that personal budgets across health and social care are included within scope.
Standing Commission on Carers	8	Section 4.3.1	With regard to our comments above about **residential colleges,** we note that many of these colleges provide rehabilitation and specific programmes after surgery, accident etc. Therefore they would seem to be eligible for inclusion.	Thank you for your comment – as explained above, residential colleges have not been added to this scope.
Standing Commission on	9	Section 4.3.2	We would prefer to see a more positive reference to **homecare** and suggest saying that homecare will be covered if…….Homecare is absolutely vital to most sustainable	Thank you for your comment. The scope reflects the fact that home care as a service is included in this

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Carers			discharges after a serious episode or illness and should be seen as such.	guideline in so far as it facilitates successful transitions. Home care services more broadly are the exclusive focus of another NICE social care guideline Home Care (under development).
Standing Commission on Carers	10	Section 4.4	We would like to see '**active engagement of user and carer in discharge planning arrangements'**. This goes beyond asking for experiences and is in line with the wider policy focus on self directed care and support.	Thank you for your comment. We agree that active engagement of people and their carers is an important aspect of discharge planning. This will be explored in the proposed review questions.
Standing Commission on Carers	11	Section 4.5.7	The above ties in with the question about **reducing unplanned or emergency hospital readmissions.** Our members cite lack of engagement with carers as a particular fact, with no real engagement of families in the discharge planning process.	Thank you for the comment. We agree that this is an issue and expect relevant material to be identified via the proposed review questions.
Standing Commission on Carers	12	Section 4.5.12	The question about unpaid support from family and other unpaid carers is very relevant. We would like to see a supplementary question about **the personal and financial implications of taking on unpaid care** (often for considerable periods of time) and whether social or health care was provided to make the carers' roles easier. We know that many carers have to reduce their hours or employment or give up work altogether in many cases because they are not supported in heavy-end care.	Thank you for your comment, which we will share with our GDG. The full impact on and role of carers during the transition process is included within the scope of this guideline.
Standing Commission on Carers	13	A general comment	**We would welcome more 'whole family assessments', ie a consideration in discharge planning as to who will be available at home to support the patient in his or her home; what support they need and what are their views about arrangements for a sustainable return home.**	Thank you for your comment. We recognise the critical importance of carers and whole families in supporting transitions and this is reflected in the scope's key areas,

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			In the context of the above, it would also be helpful to look at local equipment services and the speed with which chair lifts, bathroom hoists, hospital beds etc can be provided.	outcomes and review questions. The timely and appropriate provision of equipment to support transitions is included as a key area of the scope.
Association of Directors of Adult Social Services (ADASS)	1	General	"ADASS welcomes the development of quality standards regarding the practice of transition of patients (or rather referred to as "individuals") between health and social care settings.	Thank you for your support.
Association of Directors of Adult Social Services (ADASS)	2	General	ADASS strongly supports an outcome based approach to quality standards which in turn create a greater synergy and integrated approach between health and social care .	Thank you for your comment.
Association of Directors of Adult Social Services (ADASS)	3	General	ADASS notes that there must be Government commitment to fully fund any burden upon councils as a consequence of applying any new quality standard	Thank you for your comment. Although funding is a concern, it is not an issue routinely covered by NICE social care guidelines.
Association of Directors of Adult Social Services (ADASS)	4	General	ADASS is very concerned that the overriding premise of the proposed scope gives an impression that all activity outside the NHS Acute setting is the responsibility of adult social care. This is clearly not the case and the proposed scope must be extended to included the interface and responsibilities of community health services and support in	Thank you for your comment. Where they are coordinated with social care to improve transitions, community as well as primary health services are considered in scope as

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			facilitating effective and efficient transition from acute settings. Further it is the noted the current NHS Transfer is designed to cover more than simply the interface between health and social care and the establishment of the Better Care Fund needs to be clearly referenced in the scope"	elements of a care package. Thank you for the reference to the Better Care Fund, which we have added to the scope.
Royal National Institute of Blind People (RNIB)	1	2	As discussed in the workshop the remit of the guidance remains unclear. The impression given by the language used in the guidance is that it will cover discharge from secondary inpatient care to a social care setting. However, it is understood from conversations at the workshop that the guidance is intended to cover much wider range of multiple and parallel transitions, for example from health into other health settings or from social care to healthcare services. This broader approach is welcome and should be make clearer in the remit and in the terminology used throughout the scope.	Thank you for your comment. At the stakeholder workshop, support was expressed for the guideline to adopt a specific focus on transitions between inpatient hospital settings and community or care home settings for adults with social care needs. We have tried to make this clear in the body of the scope and have amended the title to reflect this. The title for the guideline is now, 'inpatient hospital settings and community or care home settings for adults with social care needs'. We recognise that many other transitions occur between and within the health and social care sectors. However, the effects of poor transitions between health and social care are felt most acutely when delayed transfers of care from hospital occur. The scoping group therefore decided to give the guideline a more limited focus where we believe we can achieve the

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				greatest impact.
Royal National Institute of Blind People (RNIB)	2	4.4	The fact that communication between providers and "information for patients" is part of the scope is welcomed. Communication barriers are huge for people with sight loss in the NHS. NHS England is currently developing an Accessible Information Standard to ensure that information is made accessible to people with sight loss and this needs to be incorporated into the guidance on transitions. Most blind and partially sighted people do not get NHS information in a format that they can read and this problem is particularly acute – and harmful - when transitioning from different services. For example, patients may have spent time explaining their format needs (i.e. for large print) in one hospital ward, but as soon as they move to another service their format need is no longer registered and they begin to receive inaccessible information again. This can cause massive problems because, for example, follow –up care instructions can be provided in a format which is inaccessible to the patient. This problem is pertinent to communication between providers and with patients.	Thank you for your comment. In adopting a whole adult population focus for this guideline, we recognise that this is not a homogenous group. This will be reflected in our review of the evidence. In addition, the equality impact assessment (EIA) identified certain groups who may be particularly vulnerable to poor transitions. These include people with communication difficulties or sensory impairments. Our search strategies will be oriented to seek out material on these and other groups identified in the EIA.
Royal National Institute of Blind People (RNIB)	3	4.1.1	Inclusion of sub-groups. People with sight loss are particularly at risk of inadequate care when transitioning from different services because they may need additional support needs due to their sight loss which are not communicated between service providers. People with sight loss should be included as a "sub-list" of the "Groups that will be covered".	Thank you for your comment and this useful information. We share your concerns about creating a list of sub groups, which is why we have adopted a whole adult population focus. No single condition will be

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			However, we do echo our concerns raised at the workshop that in creating a "sub-list" there is a risk of providers excluding from consideration certain "sub-groups" that are not specifically mentioned. As such we would prefer guidance which is fit-for-all and inclusive of the needs of potentially vulnerable adults and those with communication barriers. Health inequality background information: people with sight loss regularly share their concerns with RNIB about the problems that they have had in healthcare because of their sight loss and the inability of the NHS to make reasonable adjustments. We know from recent research that people with sight loss are a third more likely to experience difficulties in accessing care services than non-disabled people [S. McManus and C. Lord, "Circumstances of people with sight loss"; Natcen and RNIB: 2012]. The recent "Close to Home" - EHRC report revealed that people with sight loss: • were involved in some of the most disturbing examples of poor treatment. • found it difficult to complain • were seen as people who would be less likely to complain. • And staff unaware of the needs of people with sight loss. [Equalities and Human Rights Commission, "Close to Home - An inquiry into older people and human rights in home care "]	prioritised at the evidence review stage. However, certain groups of adults have been highlighted by the equality impact assessment including people with communication difficulties or sensory impairments.

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Royal National Institute of Blind People (RNIB)	4	4.3.1 (b) (e) (g)	We are delighted that advocacy services will be included in the scope. The beneficial role of advocacy staff in bridging the gap between health and social care also has particular relevance to points 4.3.1 (b) and (e): care planning and communication. Secondary care doctors are not equipped with the time or training to confront social care issues that arise as a consequence of their patient's ill health.[8] Eye Clinic Liaison Officers (ECLOs) are employees in an eye ward who offer a bridge between health and social care services: they signpost patients to appropriate services, talk through treatment options or diagnosis information, provide information in an accessible format and prevent patients "falling between the gaps".[9] Better informed patients with a point of contact in the hospital are less likely to seek unnecessary emergency readmissions. RNIB has published a report outlining the critical role that ECLOs play in patient care and this can be accessed at: http://bit.ly/XcLm8t	Thank you for your comment. We will share the information about ECLOs with the GDG.
Royal National Institute of Blind People (RNIB)	5	4.3.1 (l)	The need for disability training for staff should be explored. Staff can fail to accommodate the needs of patients with multiple disabilities and tend to focus their care on the immediate problem the patient is facing, e.g. a broken leg. Many people with sight loss report not having their sight loss and consequent needs addressed when they go into hospital	Thank you for your comment. We recognise the importance of learning and development and research relating to this issue will be identified via review question 4.5.13.

[8] Boyce (2012): research into issuing the certificate of visual impairment shows that doctors are reluctant to ask patients about how they are coping or because they do not have time to do so or they feel uncomfortable.
[9] Subramanian, Conway and Gillespie-Gallery (2011): for an evaluation of the current services.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
			or other care settings: this can be dangerous, embarrassing and stressful. Lack of disability awareness training affects many older people who often have multiple conditions. For example, it is estimated that 123,000 people have dementia and sight loss and up to 60 per cent of people who have had a stroke will have sight loss related to their stroke. The older someone is, the more likely they are to have both a visual loss as well as hearing impairment.[10] Therefore it is important that all staff are able to recognise the whole care needs of patients, particularly those with sight loss or another disability. RNIB supporters have developed some "top tips" for healthcare professionals working with people with sight loss: http://bit.ly/1dPjoti	
Royal National Institute of Blind People (RNIB)	6	4.3.1 (g)	Telehealth will be include in the scope and it is important that the needs of people with sight loss are explored in terms of the barriers they face to accessing information and using inaccessible equipment as outlined in point two.	Thank you for your comment. We understand that certain adults may be particularly vulnerable to the impact of poor transitions, including in relation to accessing information and equipment. Our search strategies will be oriented to seek out material on these and other groups identified in the EIA and the GDG will be asked to consider the impact of recommendations on those groups.

[10] For more information see https://www.rnib.org.uk/livingwithsightloss/otherconditions/Pages/other-conditions.aspx

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
Royal National Institute of Blind People (RNIB)	7	3.2.1 (f)	Rehabilitation and reablement are key for people newly diagnosed with sight loss, as well as those with long term sight loss who acquire an additional disability and need to re-learn how to be independent. In the past five years, between 2008 and 2013, there has been a shocking 35 per cent decline in the numbers of blind and partially sighted people getting council care and support.[11] This situation can only contribute to the number of people being unnecessarily re-admitted to hospital due to falls or other avoidable injuries due to lack of rehabilitation. For example, there is a high correlation between sight loss and falls. The Blue Mountains Eye Study concluded that visual impairment is strongly associated with older adults having two or more falls. [12]	Thank you for this information, which we will share with the GDG.
Royal National Institute of Blind People (RNIB)	8	3.2.1 (g)	Community equipment (or minor aids and adaptations) are an essential part of the care and support offering for blind and partially sighted people. For example, video magnifiers can enable patients with sight loss to read health information which has been sent to them in an inaccessible format. However video magnifiers cost around one to two thousand pounds depending on size. Currently social services authorities retain the discretion to charge for adaptations costing over £1,000 where those adaptations are made by the authority under its powers to	Thank you for this information, which we will share with the GDG. It may be worth noting that this guideline will not address how care and support is funded since this is not within the remit of NICE social care guidelines. Furthermore, it is not customary for NICE guidelines to contradict legislative intent.

[11] Kaye and Connelly "Facing Blindness Alone" RNIB 2013

[12] Ivers RQ, Cumming RG, Mitchell P, Attebo K (1998) "Visual impairment and falls in older adults: the Blue Mountains Eye Study" Source: Department of Public Health and Community Medicine, University of Sydney, New South Wales, Australia.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
			provide community care services. However as local authority budgets are tightening, it is increasingly likely that the costs of these more expensive items will not be met. We believe that these cost restrictions should be revisited in terms of what is included in the category of "minor aids and adaptations". The Community Care (Delayed Discharges etc.) Act (Qualifying Services) (England) Regulations 2003 (SI No 1196) and the Community Care (Delayed Discharges) Act s 15 England and s16 Wales have not been updated in the last decade to reflect the increasing variety and costs of equipment.	
Royal National Institute of Blind People (RNIB)	9	4.4	It is welcomed that "user and carer experience, views and satisfaction" is a key outcome measure and we would like to note that people with sight-loss will need to be offered outcome measure surveys and questionnaires in an accessible format such as large print, braille, email and audio CD and special provision should be made to alert them to the possibility of sharing their opinions.	Thank you for your comment, with which we agree. It is worth noting that the outcomes we assess and report on during the evidence review will depend on what has been used in the existing research. Of course, we will prioritise outcome measures defined from the perspective of people using services and their carers and studies that have genuinely involved service users..
Royal National Institute of Blind People (RNIB)	10	4.1.2	We echo the point made by National Voices on the exclusion on children from this scope.	Thank you for your comment. We recognise that children and young people do also experience poor transitions between hospital and community or care home settings and this has been the subject of extensive scoping group discussions. However, the group

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				agreed that the scope of the guideline would be more manageable if we excluded children under 18 years. Our view is that a single guideline covering all ages cannot do adequate justice across a wide range of issues nor secure the right stakeholder involvement. You may be interested to hear that to fill this gap, NICE has asked the Department of Health and Department for Education to consider the referral of a guideline on transitions between hospital and community or care home settings for children and young people.
Foundations	2	General	Foundations advocates that housing and housing support in the transition between health and social care is vital. Hosing, health and social care are the three points on the triangle in achieving many of the NHS, social care and public health frameworks such as preventing readmission and improving well-being amongst vulnerable and older groups. With a consideration of the home environment in the transition of patients, smoother and more efficient transition is possible. Housing support services are vital in this joined up thinking. In March 2012 Foundations contributed to a Hospital 2 Home pack which is now available. This resource provides practical help and examples to assist with the housing aspects of	Thank you for your comment. We agree that the suitability of housing is crucial to ensuring successful, appropriate transitions between inpatient hospital settings and community or care home settings for adults with social care needs, particularly in the sense that someone will be safe from harm and as independent as possible within their home. This is why housing services is included as an example of a key area that the guideline will cover. In addition, we have added a reference to the suitability of housing

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
			hospital discharge. A range of partners contributed including the British Geriatrics Society, Age UK, LGA, Kings Fund, and was supported by DCLG and DH. The resource was launched in 2012 by the DH Minister for Care and Support and is available on the Housing Learning and Improvement Network. http://www.housinglin.org.uk/hospital2home_pack/ Unsuitable homes can directly cause health problems leading to hospital admissions and consequently delayed discharges. If individuals are discharged to unsafe, cold, unsuitable homes they are more likely to return to hospital. Therefore any guidance on the transition should include explicit references to housing both in terms of assessment and support. The guidance should also seek input from housing professionals as well as clinicians and social care staff to clearly articulate the needs in transitioning an individual. The focus of new agendas with the launch of the Better Care Fund is a shift from acute to preventative measures, therefore housing is crucial to this and any guidance published around this integration agenda.	in the 'reasons for the guidance' section of the scope. This will give the issue more prominence and we have also added the useful reference to the 2011 housing strategy for England. It may be worth noting that we distinguish between the provision of housing support services to enable discharge from hospital (for example) as distinct from Local Authority Housing Needs and Options Services and/or social housing providers.
Foundations	3	3.1	**Key fact and figures** We would suggest the second paragraph should reference the lack of integration between care, support and housing. This is in line with references in the Care Bill and also the Better Care Fund	Thank you for your suggestion. The list of reasons for delayed discharges is taken from a particular source (the monthly figures released by NHS England). Issues around housing are not specifically cited in those statistics so they cannot be

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			We would also recommend adding to a bullet point in this section that people are still waiting 'for a housing needs assessment'	added at that specific point in the scope. However, as explained above, we have added a reference to the suitability of housing in the 'reasons for the guidance' section of the scope. This will give the issue more prominence and we have also added the useful reference to the 2011 housing strategy for England.
Foundations	4	3.2	**Current practice** Suggest the inclusion of reference to the Hospital 2 Home pack mentioned in the general section which was supported by the Department of Health. The resource provides clear information for professionals on how housing can be integrated to facilitate better hospital discharge with factsheets, checklists and leaflets which promote and demonstrate good practice. This pack is available on the Housing LIN website	Thank you for your comment. We have not referenced any specific good practice guidance in this section although we will share the information you have provided with the GDG.
Foundations	5	3.3	**Policy** Reference should be made to the Better Care Fund. The inclusion of Disabled Facilities Grants in this funding is clear indication that housing should be integral to guidelines on the transition from health to social care. Disabled Facilities Grants will in future become part of the Better Care Fund with CCGs and LAs working on plans now	Thank you for your comment. We have updated the scope and now refer to the Better Care Fund as opposed to the Integrated Care Fund.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
			for action in 2015/16	
Foundations	6	4.3.1	We would suggest more explicit reference to housing support and adaptations - both major and minor (inc Handyperson services) under b) include 'housing assessment' f) add 'home adaptations and repairs' g) to housing services add '(including home adaptations, repairs, housing advice and information and specialist housing)	Thank you for your suggestion. Housing services are included as an element of care packages that may contribute to ensuring timely transitions. When we refer to housing services in this context we mean the support services such as repairs and adaptations that may be made to ensure someone is safe from harm and as independent as possible within their home. We have tried to clarify this, in line with your suggestion by adding 'adaptations and repairs' under point 'g'. We have not made your other suggested additions because the list is only meant to provide examples and not be exhaustive.
Foundations	7	4.4	**Main outcomes** add 'suitability of housing' and 'access to housing support'	Thank you for your suggestion. Suitability of housing is very broad, potentially taking us beyond the scope. It may also be useful to note that the outcomes we assess and report on will be subject to those used in included studies.
Foundations	8	4.5	**Review questions** add ' What are the views of housing practitioners/policy	Thank you for your suggestion. We have not added an additional question but we have changed 4.5.4

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
			makers and how can they better contribute to coordinated transitions	to include the views of housing practitioners as well as health and social care practitioners.
The Lesbian and Gay Foundation and the LGBT – Joint response	2	4.1.1	We have some notes on the equality impact assessment for people with protected characteristics. For instance, you highlight that people who live alone may be particularly vulnerable to delayed discharge and to find negotiating transitions more difficult. We would like to point out that lesbian, gay, bisexual and trans people (LGB&T) are more likely to fall into this category. In addition, they are less likely to be able to rely on family and friends to provide informal care, and to have their needs understood and met by social care providers. Relevant evidence here includes the following: • LGB&T older people are far more likely to live alone with fewer support networks (Stonewall, 2011; Whittle et al., 2007) which means they are more likely to be isolated and/or access social care. • Social care is behind other health services in looking at LGB&T issues. The recent Equalities and Human Rights Commission report into homecare stated: "Older lesbian, gay, bisexual and trans people quite often, we have found, face harassment or misunderstanding … or ignorance of their needs in [care] services so they often have to go back into the closet for fear of the reaction that they might get from care providers" (EHRC, 2011) Also, there is a need for services to be more proactive than simply 'being sensitive to LGBT requirements' because	Thank you for your comment. We recognise that certain adults may be particularly vulnerable to the negative effects of poor transitions and they have been identified in the equality impact assessment (EIA). Our search strategies will be oriented to seek out material on these and other groups identified in the EIA and the GDG will be asked to consider the impact of recommendations on those groups. We have changed the wording of the EIA in line with your suggestion that providers need to be more proactive than simply 'responding to requirements'.

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			LGB&T people may face further barriers to accessing services or be reluctant to be open about their needs and the services they may benefit from because of the perceived risk of homophobia, biphobia and transphobia. Therefore, it is essential that service providers clearly demonstrate their openness to and acceptance of LGB&T people, for instance, by: • Monitoring sexual orientation and gender identity and analysing the data for ongoing service improvement • Using non-heteronormative language and imagery in all communications • Involving LGB&T people in service planning and delivery Necessarily commissioners also have a responsibility in this regard in terms of how they commission services.	
The Lesbian and Gay Foundation and the LGBT – Joint response	3	General	We think that discharge from hospital offers a prime opportunity to review how future admissions can be prevented so long as this is done holistically and takes into account specific needs people with protected characteristics may have. For example, the discharge process could be used to support LGB&T people to find safer, more suitable accommodation and/or LGB&T groups and organisations that can offer the support that might have been lacking in the first place.	Thank you for your comment. We understand that certain adults may be particularly vulnerable to the impact of poor transitions between inpatient hospital settings and community or care home settings, including, as you say, LGBT people. As explained, our search strategies will be oriented to seek out material on particular groups so we expect that existing research about the effects of poor transitions on LGBT people will be identified.

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National Voices	1	General	The current title of the scope suggests a wider focus than the challenges surrounding hospital discharge alone. It would be useful to understand if focus is reflective of the nature of the evidence base in this area, or if the evidence base has been identified in line with this initial focus. If the scope will remain focused on this specific area, it would be advisable to make this focus clearer upfront. There is also an inherent risk that the current wording implies that the transition between health and social care will predominantly take place following an acute episode. This runs against the wider policy drive towards more proactive and prevention-focused care in the community.	Thank you for your comment. At the stakeholder workshop, support was expressed for the guideline to adopt a specific focus on transitions between inpatient hospital settings and community or care home settings for adults with social care needs. The prevention of re-admissions to general hospital care is also an important element of this guideline. We have tried to make this clear in the body of the scope and have now changed the title to reflect this. The title now reads "Transition between inpatient hospital settings and community or care home settings for adults with social care needs".
National Voices	2	General	The wording of the scope seems to suggest in some places that transitions occur at a single point in time, and in one direction. This is often not the case and not reflective of the complexity of ongoing interactions between health and social care where people often have multiple and complex needs.	Thank you for your comment. We recognise that transitions between inpatient hospital settings and community or care home settings for adults with social care needs occur in both directions. Therefore the prevention of re-admissions to general hospital care is also an important element of this guideline. Good practice around hospital admissions for adults with social care needs will also be covered.

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				We also recognise that people make numerous transitions between and within health and social care. However, the effects of poor transitions between health and social care are felt most acutely when delayed transfers of care from hospital occur. The scoping group therefore decided to give the guideline a more limited focus where we believe we can achieve the greatest impact.
National Voices	3	General	The draft scope highlights that a lack of integration is a key factor in delayed discharge. The sections on current practice and policy make it clear previous processes have often been focussed on 'who is to blame' for the delay and penalties that result from this responsibility. These approaches have not been conducive to the promotion of more collaborative working. They have also focused on how the person can be 'moved around' the system within certain timescales, rather than focusing on individual outcomes and how health and social care services can best work together to support their return to the community. The growing drive for integration is moving away from health and social care being viewed as separate entities that come together at a specific point in time. Bearing in mind the timescales for the development of this guideline, it would be good to ensure that it is 'futureproofed' in relation to the likely direction of travel. Already it is clear that areas that are advancing their coordinated care plans are likely to 'co-locate' their health and social care teams, or even to bring them together with	Thank you for your comment. We have updated the scope and now refer to the Better care Fund as opposed to the Integrated Care Fund. We are keen to ensure that the final guideline will be relevant to practice at the time of publication and will work with the GDG to achieve this. We agree with you about the importance of understanding the outcomes of transitions from the service user perspective and improving care and support on the basis of this evidence. The outcomes we assess and report on during the evidence review will depend on what has been used in

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			other professionals in multi-disciplinary teams. Recent reports suggest the Better Care Fund application process is further stimulating local authorities and CCGs in some areas to consider pooling whole budgets for health and social care. In finalising the scope of these guidelines, we have an opportunity to ensure that professionals focus on how we can improve how 'transitions' are experienced from the point of view of the person, rather than from a service perspective. The Narrative for person-centred, coordinated care, sets out what person-centred, coordinated care, across health and social care, would look and feel like to someone experiencing it. This has been drawn up in collaboration with people who use services and a range of national stakeholders. This includes a specific section on transitions, looking at the importance of contingency planning, the person feeling confident about what will happen next, and having a main point of contact throughout the process. By approaching the issue in this way, the 'transition' from a hospital setting to the community can be seen in a more holistic way, as part of a person's 'journey' to living and staying as well as possible, rather than as an isolated event.	the existing research. Of course, we will prioritise outcome measures defined from the perspective of people using services and their carers.
National Voices	4	4.1.2	We are disappointed to see that the draft scope of the document means that anyone under the age of 18 is not covered explicitly. Developing recommendations for adults and then 'considering their applicability to children' – as though children are just 'little adults' – does not seem appropriate. Again there is a need to take account of the direction of travel whereby, for example, children with special educational needs will soon be entitled to a combined 'education, health and care plan'.	Thank you for your comment. We agree that considering the 'applicability of recommendations to children' may seem as though they are viewed as an 'add on' and may also be rather confusing. We have therefore removed this reference from the scope. We do recognise that children and

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			The issue of transfer for children from health into social care is an important one. It should be clarified how this will be considered as part of the process of developing the guideline and ensure that the additional factors that are particularly relevant to a child's development, health and wellbeing, such as access to education, play and leisure, are taken into account.	young people also experience poor transitions between hospital and community or care home settings and this has been the subject of extensive scoping group discussions. However, the group agreed that the scope of the guideline would be more manageable if we excluded children under 18 years. Our view is that a single guideline covering all ages cannot do adequate justice across a wide range of issues nor secure the right stakeholder involvement. You may be interested to hear that NICE has asked the Department of Health and Department for Education to consider the referral of a guideline on transitions between hospital and community or care home settings for children and young people under the age of 18.
National Voices	5	4.3.1(b) and (e)	As part of the activities covered, it might be useful to consider where the role of a care and support partner (an individual who works with a person on their care and support planning) fits into these discussions. As part of our work on care and support planning (referenced below) we have explored the key competencies of such a role and identified how they would help to coordinate care and facilitate communication between the wider team of professionals and supporters working with the person.	Thank you for your comment. We would consider the support for good quality transitions provided by carers and support partners is within scope, under care planning and review, including discharge planning.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
			In such circumstances, such a person could play a role in providing a connection between any care and support that was provided prior to hospital admission and work with the person and any secondary care professionals to consider if and how this care and support may need to change following their return to the community.	
National Voices	6	4.3.1(d) and 4.3.1(i)	The document currently recognizes 'self-directed support and use of a personal budget, based on a jointly agreed social care plan' as an activity that is in scope. We would like to see recognition of the growing potential of joint personal budgets, agreed via joint care and support planning processes across health and social care, in supporting better transitions back into a community setting. This may also have implications for people where coexisting health and social needs may be met in a more coordinated way, following discharge (e.g. a personal assistant could be trained to change dressings)	Thank you for your comment. We recognise the importance of personal budgets across health and social care and recognise that these may improve the quality of transitions. The scope has not been changed because the list of key areas is intended to provide examples rather than be comprehensive.
National Voices	7	4.3.1 (g)	It might be useful to consider including the role of emergency support plans in preventing readmissions to hospital within 28 days. Research by NV members, the MS Society, has shown that effective emergency support planning can help to prevent hospital readmissions. For example, throughout 2010 the MS Society supported East Sussex County Council in piloting an innovative relapse support service. The County Council provided each person on the pilot scheme with a small sum of money. They were able to determine what support would be best for them in the event of a relapse, which could potentially result in a hospital admission, and to choose when to purchase this support. Each individual completed a relapse support plan detailing	Thank you for your comment. The prevention of hospital re-admissions is a key aspect of the scope. We will pass on this specific information to the GDG.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
			the type of support they would like to use if they have a relapse. The service enabled people to feel secure, knowing that support would be readily available if and when they needed it. This pilot showed that by having information upfront on what options are available if an individual has a sudden change in their condition can make a real difference to an individual's sense of control and can support a person to effectively meet their needs and avoid hospital readmission.	
National Voices	8	4.3.2	Currently it is suggested that 'care planning and provision that does not directly impact on the transition between health and social care' should not be in scope. We would like to clarify what elements of care planning and provision would not be relevant to consider when preparing for hospital discharge. When someone if preparing to leave hospital, it is important that the outcomes of any previous care and support planning discussions are taken into account. This will allow the person and the professional(s) involved to consider the person's return to the community in the broadest possible way and anticipate what types of support might be necessary to ensure that they retain the skills, confidence and knowledge to live as independently as possible. Care and support planning and timely transition planning are key mechanisms to ensure that the person and their family or carers stay central to discussions and planning decisions at all times. National Voices and partners are also increasingly moving towards the wording 'care and support planning' and this recognizes the language from both health and social care and signals that discussions are both about what care can be arranged for the person, and what actions they may be able	Thank you for your comment and useful suggestions. The wording of the scope has been altered to try and be clearer about the settings that will not be included. We have also used the term 'care and support planning' wherever possible. Thank you for the additional information, which will be shared with the GDG.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
			to take themselves to stay and live well. The latter may often include connecting to support within the local community, which will be particularly important to prevent any potential issues resulting from social isolation. We are currently creating a public facing guide which sets out what good care and support planning should look like. More information about this project can be found here. The final version of the guide will be launched in early March.	
Royal Pharmaceutical Society	1	General	The Royal Pharmaceutical Society, the professional body for pharmacists and pharmacy welcomes social care guidance on the transition between health and social care. Integration between care settings and healthcare professionals working in those settings is critical. As patients transfer between health and social care so do their medicines and pharmacists often sit at the interface playing an integral role in ensuring that this transfer is safe. Research has consistently shown that there is significant risk that patient's medicines will unintentionally altered when they move care settings. We know that between 30 and 70% of patients have either an error or an unintentional change to their medicines when their care is transferred.	Thank you for your comment. The management and review of medicines is included in 'care planning and review (including discharge planning)'. In particular, we anticipate that research relevant to the issue will be identified via the review questions about what works well in the transition from inpatient hospital settings and community or care home settings – both from the practitioner and service user and carer perspective.

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			We have published professional guidance for healthcare professionals on keeping patients safe when they transfer between care providers. We would like to highlight the four core principles in our guidance for healthcare professionals, which are: 1. Health care professionals transferring a patient should ensure that all necessary information about the patient's medicines is accurately recorded and transferred with the patient, and that responsibility for ongoing prescribing is clear. 2. When taking over the care of a patient, the healthcare professional responsible should check that information about the patient's medicines has been accurately received, recorded and acted upon. 3. Patients (or their parents, carers or advocates) should be encouraged to be active partners in managing their medicines when they move, and know in plain terms why, when and what medicines they are taking. 4. Information about patients' medicines should be communicated in a way which is timely, clear, unambiguous and legible; ideally generated and/or transferred electronically. The RPS recommends that research and recommendations from our report and guidance are taken into consideration in the development of the NICE guidance.	
Rethink Mental Illness	1	4.3.2	We are disappointed that specialist inpatient and community mental health settings will not be covered by this guidance. We feel this is incompatible with the current focus on parity between physical and mental health. Ideally, we would like to see all settings providing health and social care covered in	Thank you for your comment. We agree that the issue of transitions between acute mental health settings community or care home settings are critically important. The

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			this scope. However, we would hope that if these settings are not covered in this guidance, there will be separate guidance published for mental health. People affected by mental illness account for over 20% of social care activity (Community Care Statistics: Social Services Activity, England, 2012-13). This is a significant proportion of people supported by social care. As a large number of this group will be moving from specialist mental health settings, it is important their experience of transition and their outcomes are improved. We know, for example, that there are a number of challenges locally with things like community care assessments for people affected by mental illness. Joint guidance on transitions might help clarify some of these issues and ensure that people are not being excluded from support they are entitled to. While we acknowledge there are certain legal and policy frameworks relating to mental health, this is also true of other health conditions. The Care Bill (2013) and Health and Social Care Act (2012), for example, are relevant to the transitions currently covered by the scope. The principles underpinning good transitions, such as effective discharge, reduced readmissions and better 'step-down' provision are equally relevant to mental health settings. We feel that guidance and practice should be relevant regardless of the legal framework.	scoping group has discussed the issue extensively. The group felt that to address transitions from acute mental health settings adequately, the topic should be dealt with separately. In light of this the Department of Health has now confirmed that transitions between inpatient mental health settings and community or care home settings for people with social care needs will be covered in a separate NICE guideline (to be referred).
Royal Mencap Society	1	General	**Introduction** People with a learning disability die earlier than the general population. They are 58 times more likely to die before their 50th birthday. They die unnecessarily in the health service	Thank you for your comment. Adults with learning disabilities moving between inpatient hospital settings and community or care home settings are included within scope.

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			because of poor communication from staff, lack of basic care, delays in diagnosis and treatment, failure to recognise their pain and staff not following guidance around mental capacity or resuscitation. Mencap has been campaigning and influencing on health issues for nearly 10 years. This work has helped to change attitudes in the medical professions and started an important process of change in the way people with a learning disability are treated. However, there is still a long way to go, and the recently published report from the Confidential Inquiry into premature deaths of people with a learning disability showed the scale of the challenge, revealing that 1,200 people with a learning disability are dying unnecessarily in the health service each year. This is profoundly shocking and must stop. From cases Mencap has heard about we know that people with a learning disability are at risk of unsafe discharge from hospital, which can have serious consequences. We welcome that the pre-scoping work for the consultation on this NICE guideline around transition between health and social care settings identified the need to specifically focus on people with cognitive impairment, older adults who may lack capacity and people with communication difficulties and/ or sensory impairment. We think it is very important that there is a specific focus on the needs of all people with a learning disability. Below, we set out why this specific focus on people with a learning disability is needed, and what issues should be addressed. Below, we set out why, the importance of only discharging	As the guideline will focus on the whole adult population, we would try to avoid specifying particular groups at this stage. Our search strategies will identify existing evidence pertaining to all adult service user groups, including adults with a learning disability.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
			people with a learning disability when they are clinically fit for discharge, the steps that should be taken to ensure a good transition from hospital to home, the importance of ensuring that the person gets the healthcare support they need at home, and what steps can be taken to prevent the need for further admissions to hospital. We would urge the NICE guideline to address all these issues.	
Royal Mencap Society	2		**What Mencap believes the NICE guideline should address** **1. Risk of premature/ unsafe discharge** We know that too often, a person with a learning disability can come into A&E and be discharged without diagnosis or treatment. This might be because their means of communication is not understood properly. They may be expressing pain through their behaviour but hospital staff may just think their behaviour is 'part of their disability' (diagnostic overshadowing). As a result, heath conditions may not be picked up and the person may be sent home without the treatment they need. We know that too often hospital staff are not following the Mental Capacity Act, which can result in them not getting the treatment they need. Eg a person may 'refuse' to give blood because they don't like needles, when actually they may not have capacity to make this decision. People should get the support they need to make their own decision, but if they don't have capacity to make a decision, a decision must be made in their best interests. It is important staff know how to assess whether someone has capacity to make a decision/	Thank you for your comment. As identified in the equality impact assessment, we recognise that certain adults may be particularly vulnerable to the negative effects of poor transitions planning. Our search strategies will be oriented to identify material relating to these groups and the GDG will be asked to consider the impact of recommendations on those groups.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
			refuse treatment. We know that too often hospital staff are not following the Equality Act and making reasonable adjustments, such as taking the time to listen to families, who will often have very valuable information to share and be able to interpret the person's communication (involving families is also required under the Mental Capacity Act, when the person lacks capacity). Reasonable adjustments can also include using different methods to assess pain, which can be important when someone doesn't use formal communication. If reasonable adjustments are not made, again, people's needs may not be understood/ concerns picked up, and as a result the person may not get the treatment they need and be sent home prematurely.	
Royal Mencap Society	3		We know that sometimes people with a learning disability can present behaviour that challenges and as a result they can be discharged prematurely as hospital staff find their behaviour 'too difficult' to manage on the ward. This can be a particular risk when hospital staff thinks the person is supported by 'nursing staff' or equivalent at home. We know that hospital staff do not always understand the difference between nursing homes and care homes. They may think that when the person is discharged they will be able to get nursing care at home when that is not the case. This is a real concern as we know that often social care staff have not had the training to manage serious health needs, so it can be dangerous to assume they will be able to deliver the sort of health support that the person would get in hospital or from nursing care staff.	Thank you for your comment. We anticipate that evidence relating to these issues will be identified via review questions about works well in discharge from hospital, form a practitioner and service user and care perspective

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			In situations where people present behaviour that challenges it is important that a care plan and risk assessment is developed to manage the person's behaviour on the ward, in addition to carrying out appropriate explorations to understand why the person may be presenting challenging behaviour in the first place. It is crucial that people with a learning disability are only discharged when they are clinically fit to be discharged, not just because their behaviour is considered difficult to manage on the ward	
Royal Mencap Society	4		**2. Decisions about discharge, managing the transition, supporting someone at home** It is important that additional checks are done when making a decision about whether to discharge a vulnerable person. This will help make sure that a good decision is made and a person with a learning disability is not discharged prematurely. For example, it could be that there is a requirement for the learning disability liaison nurse at the hospital to be involved when a decision is made about whether or not to discharge a person with a learning disability. We know that this is what happens at St Georges hospital; the learning disability liaison nurse signs off the discharge plan. This was introduced to address a 'revolving door' issue – where people with a learning disability were being discharged prematurely and then re-admitted soon after. It is important that the discharge planning meeting involves the person and everyone who will have a role to play in	Thank you for your comment. Discharge planning is a key area within the scope of this guideline.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
			supporting the person once they leave the hospital. There will sometimes be complicated steps for the person to take, for example, they may need to take medication, wash in a particular way etc. and it needs to be established that the person understands what they need to do, or has the support they need to do it. It will be important to review the capacity of the GP and community team to support the person and/ or their family or social care staff when making a decision about discharge. It may be necessary for the person's social worker to be at the discharge planning meeting, as the person may need extra support for a period of time in their home setting. It is important that the transition is well-managed. We know it can be very useful when the learning disability nurse at the hospital has good links with the community team and together they can ensure that the right support is in place for the person when leaving hospital. It should be seen as a reasonable adjustment for the learning disability liaison nurse to let the GP and community team know in advance when a person with a learning disability is due to be discharged. This will ensure that the person with a learning disability can get the support they need straight away, without having to chase, which could be very difficult for them, if they are in a vulnerable state.	
Royal Mencap Society	5		**3. Preventing the need for further admissions** It is important that the health support and treatment the person needs is recorded in their health action plan or equivalent. So that steps can be taken to ensure that the person stays as healthy as possible and re-admissions are prevented. It may be that support staff will need training to	Thank you for your comment. The prevention of avoidable admissions to general hospital care is an important element of this guideline. We recognise that certain adults will be more vulnerable to avoidable admissions than others and this will

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			better support the person to manage their health. Particular groups of people can be vulnerable to certain conditions and it is important that these risks are included in a person's health action plan and what steps could be taken to prevent these conditions arising/ ensure they are managed well if they do arise. For example, risks around choking could be flagged up here, or the need for a person to begin needle de-sensitisation programme (if they are likely to need blood tests in the future). Everything should be put in place to prevent the need for a person to be admitted to hospital. Mencap also believes it is important that people with a learning disability are flagged as having a learning disability on the GP and hospital system. We know this is already happening in some areas. This will help ensure people with a learning disability get the right support as quickly as possible, when they come into contact with the health system. Anoynmous information should also be collected, which shows people with learning disabilities' journeys through the health system. This will help us understand when/why people with a learning disability are being admitted to hospital, when/ why people are being prematurely discharged, and what the consequences are. All this should help ensure that changes are made to improve healthcare for people with a learning disability. Something we know is still urgently needed.	be addressed in the guideline.
Alzheimer's Society	1	General	Alzheimer's Society welcomes the development of this guideline. People with dementia are core users of both health and social care services. Up to one quarter of all hospital beds is occupied by a person with dementia and over 80% of	Thank you for your support.

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
			care home residents have dementia or significant memory problems. UK Home Care Association report that over 60% of people receiving homecare have some form of dementia. Yet, there are serious issues with the quality of services and the transitions between care settings. As the 2012/13 Care Quality Commission inspections confirm, people with dementia continue to experience poor care in hospitals, stay longer and are more likely to be readmitted. Issues in hospitals for people with dementia, including discharge planning and reporting, are well detailed in the National Audit of Dementia in Hospitals. It showed that less than half of hospital boards are routinely reviewing performance in relation to readmissions and delayed discharges of people with dementia. These are important issues to consider within this guidance.	
Alzheimer's Society	2	General	The title of this guideline is somewhat broader than the scoping content which focuses primarily on hospital discharge. In addition to the issues in hospital discharge, this guideline could be strengthened by including a wider focus which recognises the movement of people from their place of residence into hospital. For instance, homecare workers or care home staff are well placed to advise and support person-centred care when a person with dementia goes into hospital. Staff should be consulted and share care plans that detail information such as personal care and preferences relating to food and drink. This is especially important for those people living alone who do not have a carer to advise or assist during a hospital stay.	Thank you for your comment. We recognise that transitions between inpatient hospital settings and community or care home settings for adults with social care needs occur in both directions. Therefore the prevention of avoidable admissions to general hospital care is also an important element of this guideline. We also recognise that people make numerous transitions between and within health and social care. However, the effects of poor transitions between health and social care are felt most acutely when

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				delayed transfers of care from hospital occur. The scoping group therefore decided to give the guideline a more limited focus where we believe we can achieve the greatest impact.
Alzheimer's Society	3	General	The guidance should also explore how people continue to interact with health care services after they move into a care home. There are major issues in these areas which demonstrate that integrated transitions between health and social care are not occurring. People with dementia should have access to the same level of support from health and care services in care homes as they would in the community. Alzheimer's Society report into the experience of people with dementia living in care homes, Low Expectations, found that 56% of respondents said access to a GP was good, but only 36% said access to other health services was good, and 23% said access to dentists was good, with large numbers of respondents saying they didn't know. To support successful transitions, care plans must be developed by care home providers in conjunction with health services and reviewed regularly. This importance of appropriate information sharing between providers and receiving timely support in the right environment is highlighted by the CQC's finding that among people living in care homes hospital admissions for avoidable conditions are 30% higher for people with dementia compared to those without dementia.	Thank you for your comment. We agree that integrated working between health and social care is vital for improving transitions and consider it to be within scope.
Alzheimer's	4	4.3.1	Alzheimer's Society suggest widening the scope of this guidance to ensure that end of life care, in particular preferred place of death, is recognised prior to moving from a care	Thank you for raising this. Transition between inpatient hospital settings and community or care home

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Society			home or home to hospital. Gomes et al (2011) found that 63% of the general population say that they would like to die in their own home, yet only 20.8% of people actually do so (Office for National Statistics, 2011). Advance care planning is an important element of ensuring that this outcome is met. Yet many people with dementia despite their wishes, die in a hospital setting. In 2012/13 the number of patients with dementia who died in hospital was more than a third higher (36%) than similar patients who did not have dementia. Many of the problems identified in our report, My life until the end, stem from a lack of coordination in care. Carers frequently reported having to state details of care plans to each of the different professionals involved in care. Furthermore, there is significant evidence that suggests that moving someone with dementia to an unfamiliar environment, such as hospital, in the later course of the illness, can be difficult and distressing for the person. Given the strong focus on integrated care within this guideline, Alzheimer's Society believes that consideration should also be given to the instances were a transition to a hospital should be avoided. There needs to be a concerted effort to ensure that hospital admissions for people with dementia in the later stages of life happen only when appropriate. There also needs to be a drive to recognise when people with dementia in hospital are at the end of their lives, and to treat them appropriately.	settings during end of life care is within scope. The issue is covered by question 4.5.11. We have updated the scope to include end of life care in 'key areas'. As well as ensuring smooth transition from hospital, we agree about the importance of avoiding unnecessary transitions into hospital. Avoiding hospital re-admissions (within 30 days) will therefore be covered by the guideline and we will also include the prevention of avoidable admissions, where this has involed a transition to a step up facility such as an intermediate care unit. Admission avoidance that does not specifically involve a transition between settings is a much wider topic and is out of the scope of this guideline.
Alzheimer's	5	4.3.1	Under Key areas that will be covered, Alzheimer's Society believes that the (e) communication and information sharing	Thank you for your comment. We consider this to be an important

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Society			should include specific attention to the data issues that currently exist between health and social care and the impact this has on transitions. To successfully achieve integrated care practitioners need to have information about patients in a compatible format. Furthermore, staff need to be sufficiently trained in obtaining, using and sharing patient data.	aspect of communication and information sharing and it is therefore within scope. The list provided under key areas is intended to provide examples rather than be exhaustive.
Alzheimer's Society	6	4.3.2	Alzheimer's Society considers that home care should be a key part of this guidance. As noted above, staff such as home care workers hold invaluable knowledge about their service users that could support transitions into hospital. Sharing this information and any relevant care plans with hospitals upon admission would support the individual's stay and discharge from hospital.	Thank you for your comment. Home care as a service is included in this guideline in so far as it facilitates that transition. Home care services more broadly are the exclusive focus of another NICE social care guideline (topic 1 – home care).
Alzheimer's Society	7	4.4	In line with extending this scope to consider place of death (outlined in comments on 4.3.1), the outcomes should also seek to identify where people die and whether the transition into hospital was appropriate.	Thank you for your comment. It is worth noting that the outcomes we assess and report on during the evidence review will depend on what has been used in the existing research. Data about place of death will also be available because it is a key indicator for end of life care.
Alzheimer's Society	8	4.5	Question 4.5.13 on training should also take into consideration the importance of training on NHS Continuing Health Care as this can be a barrier to successful hospital discharge. All staff need to be trained, from both the health care sector and local authorities, on how to use the National Framework.	Thank you for your comment. We recognise the importance of staff learning and development in relation to successful transitions and this will be explored in review question 4.5.13.
Leonard Cheshire Disability	1	General	The intended scope of these guidelines is a little unclear in places. The overall emphasis seems to be on single transitions between hospital and social care settings or a person's own home. However in some places the scope	Thank you for highlighting this. At the stakeholder workshop, support was expressed for the guideline to adopt a specific focus on transitions

Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
(LCD)			appears to be wider. Some clarification on this would be helpful. We would support a wider scope which recognises the variety of settings that people move between and the frequency of such moves. Single 'one off' transitions from hospital to social care are not the reality for many people, particularly those with multiple complex needs who may move frequently between a variety of health and social care settings. The exclusion of homecare, community mental health settings and reablement services for people with acquired brain injuries (ABI) is also particularly problematic in this context. To ensure that these guidelines are fully effective and supportive of the wider integration agenda, they would benefit from a wider scope which recognises the multiple (and often frequent) moves that people make, and which encompasses all the various settings that this can be between. For example, it is important that moves between social care settings are recognised e.g. where someone moves from a care home to a care home with nursing. This is particularly important as funding streams may change e.g. from local authority funding to NHS continuing care which effectively amounts to a transition between health and social care. If the focus is solely intended to be on hospital discharge practices, this should be made explicit in both the scope and the guidelines to ensure that the guidelines are easily applicable and effective.	between inpatient hospital settings and community or care home settings for adults with social care needs. We have tried to make this clear in the body of the scope and have amended the title to reflect this. The title for the guideline is now, 'Transition between inpatient hospital settings and community or care home settings for adults with social care needs'. We recognise that many other transitions occur between and within the health and social care sectors. However, the effects of poor transitions between health and social care are felt most acutely when delayed transfers of care from hospital occur. The scoping group therefore decided to give the guideline a more limited focus where we believe we can achieve the greatest impact.
Leonard Cheshire	2	General	**Funding** Ordinary residence: a focus on issues associated with the	Thank you for your suggestions. It is worth noting that NICE social care guidelines do not cover how care

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Disability (LCD)			movement of individuals between different local authority and CCG areas is essential. In addition a focus on effectively delivering care and support for people who receive funding through multiple streams is also important. Where conflicts between funders arise this can result in poor/inconsistent service. This is a particular issue where people's needs increase and there is a conflict between the local authority and CCG around who should meet the costs of this. Further, it is vital that the guidance adequately promotes investment in reablement. When delivered at the appropriate time, reablement services deliver significant benefits both to individual service users, and to local authority and health service budget holders. This guidance presents an excellent opportunity to promote these efficient interventions as much as possible.	and support is funded, or the mechanisms of commissioning, setting up personal budgets or making direct payments.
Leonard Cheshire Disability (LCD)	3	4.1.1	**Groups that will be covered** Whilst it is important that this guidance provides overarching principles applicable to all adults, it is also important that guidance on this topic effectively differentiates between the needs of different groups, e.g. • Elderly people; • Adults with a physical disability; • Adults with a learning disability; • Adults with a sensory impairment; • Adults with reablement needs; and • Adults with a combination of the above.	Thank you for your comment. All adults are considered to be the population of interest. Many of the groups you have listed have been flagged in the Equality Impact Assessment (published with the scope). This means that our search strategies will be oriented to seek out material on these groups and the GDG will be asked to consider the impact of recommendations on each one.

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			The care and support needs of these groups will be very different as will the desired outcomes.	
Leonard Cheshire Disability (LCD)	4	4.2.2	**Settings that will not be covered** It seems unnecessary to include 'settings in which neither health nor social care is provided'. If this reference is included for a particular reason, it would be useful to contextualise this further with a brief explanation or an example of a particular setting that would be excluded.	Thank you for highlighting this. The wording of the scope has been altered to try and be clearer about the settings that will not be included.
Leonard Cheshire Disability (LCD)	5	4.3.1	**Key areas that will be covered** Point (c) would be strengthened by referring to information *and advice*. It is important that, in addition to being provided with information, people are also supported to understand and evaluate the options available to them so that they can exercise informed choice and control over their care. In this context, we are pleased to see a focus on advocacy included in this scope. Point (e) would be strengthened with an additional focus on the roles and responsibilities of health and social care staff in relation to transitions between health and social care settings. It is important that the responsibilities of key staff in both sectors are clearly defined and widely understood. Training and development are an essential part of this and the guidance would benefit from an additional focus on this. For example, it is important that hospital staff are trained in proper discharge policy, with a clear understanding of the 'step down' process and how they should organise hospital	Thank you for your comment. The provision of advice about care and support options is implied within 'information for services and carers during transition'. We therefore expect that it will be covered in the guideline. Your other points about training and development and the responsibilities of practitioners in relation to information sharing would also be within scope as would the importance of good communication. The list of key areas however is intended to provide examples rather than be comprehensive.

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			discharge for people with particular needs. It is also important that both health and social care staff are familiar with processes for admitting people to 'step up' services which can help to avoid unnecessary hospital admissions. The promotion of good communication between health and social care staff is also vital. Too often staff from the health sector do not have the required knowledge of available care services, and vice versa. By promoting both proactive and reactive communicative between the sectors the duplication of services would decrease, and fewer service users would fall between the gaps in provision.	
Leonard Cheshire Disability (LCD)	6	4.3.2	**Areas that will not be covered** **Care planning** It is important to recognise that good care planning and provision can help to prevent avoidable hospital admissions and readmissions and delay the onset of further care needs. As such, it is important that these guidelines take a holistic approach and that good care planning be included as a whole. The quality of care planning for individuals will have a major impact on the quality and frequency of their transitions between health and social care services. Effective personalised care planning is essential to ensure successful transitions. Evidence shows that where people are well supported to manage their own health, not only do they feel more confident in their everyday lives and have a higher quality of life, but they also show improved clinical outcomes (Newman et al, 2004). Supporting people to self-care through	Thank you for your comment. We agree that the role of care planning is vital for supporting timely hospital discharge and ensuring that re-admissions are avoided. The role of care planning in supporting transitions will be considered during the evidence review process. .

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			care planning can also reduce GP visits by 40% for high-risk groups (Fries and McShane, 1998) and reduce hospital admissions by 50% (Montgomery et al, 1994).	
Diabetes UK	1	3.1	The following bullet point should be added to the list for reasons for delayed discharge: - Because the service which would be the most appropriate is not available in their area.	Thank you for your suggestion. The list of reasons for delayed discharges is taken from a particular source (the monthly figures released by NHS England). The addition that you have proposed is not cited in those statistics so it cannot be added at that specific point in the scope.
Diabetes UK	2	4.3.1	In the list of key areas that will be considered, we welcome the inclusion of bullet point (i). This is important for diabetes care as it is estimated that one care home resident with diabetes is admitted to hospital approximately every 25 minutes due to failings in screening and training. Additionally, an assessment found that 60% of care homes with residents with diabetes had no training provision (Diabetes UK, awareness, screening and training).	Thank you for this information, which we will share with the GDG.
Diabetes UK	3	4.4	Can the bullet point 'availability and appropriate/ suitable social care' be added to this list.	Thank you for your comment. Although this is an important issue it is difficult to see how it could be used as an outcome measure. It is also worth noting that the outcomes we assess and report on are subject to those identified in the included research evidence.
Diabetes UK	4	4.5.13	This point could be expanded to include the lack of availability of training (where appropriate) and the impact this has on health and social care staff and the transition between	Thank you for your comment. The review question has been drafted to be broad enough to consider all

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			hospital and home.	aspects relating to training including the lack of availability.
Royal Borough of Kensington & Chelsea Independence Support Team	1		I would comment on age, the documents appear to be predominately older person orientated particularly in examples given. Even though the scope says it includes anyone over 18 I found it hard to relate to the work my team undertakes with regard to transition from children to adults services health and social care with both health and social care needs.	Thank you for highlighting this. The population of interest for this guideline is all adults, aged 18 and above. We have tried to make this clear within the scope and we will certainly ensure that the needs of all adults are addressed by the evidence review process and in the development of the recommendations.