NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

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

Date of quality standards advisory committee post-consultation meeting:
9 June 2016

2 Introduction

The draft quality standard for transition between inpatient hospital settings and community or care home settings for adults with social care needs was made available on the NICE website for a 4-week public consultation period between 18 April 2016 and 17 May 2016. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 28 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

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

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

3. Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

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

Stakeholders were also invited to respond to the following statement specific questions:

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

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- Wording should be “adults who require care and support”, not “adults with social care needs”, in line with the Care Act.
- Greater recognition should be given throughout to:
    - Family and carers
    - People with dementia
    - People approaching end of life
    - Different communication needs
    - Cognitive impairment and reduced capacity
    - Voluntary sector involvement
- Timing of discharge should be considered
- Problems should be examined separately by age group, and whether admissions are planned or emergency.
- Need for follow-up care by hospital or GP should be agreed in advance
- References should be made to:
    - care home providers
    - medicine self-administration policies
    - NHS Continuing Healthcare
    - National Audit of Intermediate Care.

Consultation comments on data collection and resource impact

- Local systems are not currently in place – investment in basic infrastructure needed so as not to divert resource away from basic process.
- Admission and discharge services are already stretched – resources are insufficient to add a further layer of planning and measurement.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

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

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- It is very difficult to anticipate reasons for admission and therefore to know what to include in a contingency plan (although simpler for elective admissions)
- Difficulties with risk stratification
  - either people at risk are missed or too many people are identified, increasing workload
  - tools do not always include social care needs
- Practical issues due to:
  - Staff shortages
  - Large number of people eligible
- Who is responsible for developing and sharing the plan?
- Content of plan should be defined and include plans for self-administration of medication and a recognition of housing associations
- Planning doesn't necessarily improve people's experiences
- Older people with long term conditions will already have a health and social care plan.

5.2 Draft statement 2

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

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Additional triggers for the assessment:
  - Absence of significant carer
  - Sensory impairments
  - Learning disabilities
- Who should do the assessment?
  - Workforce implications for geriatricians
  - Specialist can do assessment instead of geriatrician if person admitted for specific diagnosed condition
- Support of voluntary sector could be involved
- ‘Geriatric’ is disempowering and not in line with Care Act
- How does this assessment link to Continuing Healthcare assessment?
- Suggested additional outcome measures:
  - Assessment doesn’t necessarily lead to an effective long term plan – plan is the outcome
  - Assessment also helps improve care while in hospital
- How can you measure the quality of the assessment?
- Difficult to collect data on complex conditions
- Assessment should not delay discharge
- If CGA has been done in the past, could just be updated.

5.3 Draft statement 3

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

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Should be a named discharge coordinator
- Could be the role of a dementia support worker
- Should be a dedicated role
- Effective MDT approach is required to ensure coordination
- There should be a link with a person's care coordinator
- Further training will be required for people taking discharge coordinator role
- Role of discharge coordinator should include:
  - Assessment of home circumstances, including fire risk
  - Assessment of nutritional needs
  - Ensuring assessments for Continuing Healthcare are completed
  - Arranging care and support services and transport
  - Discussing the timing of discharge with patient and carer
  - Signposting to social care support outside hospital
  - Sharing information with social care
  - Creating a discharge plan – merge with statement 4?
  - Referral to advocacy services if necessary
- Should be identified as soon as possible after admission
- Statement may not be affordable, however may result in savings from reduced length of stay and improved patient experience
- It is not always necessary for all adults with social care needs.

5.4 Draft statement 4

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

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Suggested content:
  - Assessment of person’s living environment and housing
  - Details of person’s preferences, including communication and information preferences – dependent on capacity
  - Who to contact if any problems
  - Awareness of malnutrition
- Should align with statement 1
- Is it supplementary to care and support plans?
- How will the plan be shared and with who?
- Can this statement reduce hospital admissions?
- Process measure is not meaningful to patients
- How to measure the quality of the plan?

5.5 Draft statement 5

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

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- Carers/family members need to be identified by the adult with social care needs
- It is important that the person agrees with family and carers being involved
- Carers must be willing and able
- Carers should be given information on local services and support for the person and for themselves – 24 hours before discharge
- There should be a section on what this statement means for carers
- Should distinguish between paid and unpaid carers
- Professional care providers also need to be involved in conversations about discharge
- People who do not have carers are particularly vulnerable and need support in discharge planning
- Measurement may be difficult and result in additional capacity constraints.

5.6 *Draft statement 6*

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

Consultation comments

Stakeholders made the following comments in relation to draft statement 6:

- Statement doesn't add anything to statement 4 unless the list
  - Helps people to understand their medication and how to take it
  - Includes information about changes that have been made in hospital and why
  - States what follow up is needed e.g. GP review
  - States whether the person is able to self-administer medicines
  - Is in an accessible format (see Accessible Information Standard)
- However, some felt it could be missed if part of statement 4 and should remain separate.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Coordination of care post-discharge
- Follow up after discharge
- Quality of information provided to people choosing a care home while in hospital
- Timely assessments for Continuing Healthcare
- Early supported discharge
- Access to community services.

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Stakeholder	Section	Statement No	Comments Please insert each new comment in a new row
1	Alzheimer's Society	General	General	There is huge variation and unacceptable practice across the country when it comes to discharge. The following figures have been calculated from a series of Freedom of Information requests. Last year, 4,926 people with dementia were discharged between 11pm and 6am. In the three worst-performing hospitals, four to five people were being discharged overnight per week (FOI request, 2015 – response from 68 trusts). Discharge at night is unsafe, disorientating and distressing. People are more likely to leave without relevant information, the correct medication or the right support in place because staff are not on duty to discharge them properly. Similarly, GPs and support workers are less accessible to help someone resettle or help if they have a problem. This dangerous practice must stop. Last year, 7.4 per cent of people over 65 who were readmitted to hospital within 30 days were people with dementia. However, in the worst-performing hospital 52.3 per cent had dementia, and in the next three worst-performing hospitals, the figure was between 18.7 and 24.4 per cent (FOI request, 2015 – response from 73 trusts). Last year 7.7 per cent of people with dementia admitted to hospital from home were discharged to a care home following their stay. In the three worst-performing hospitals, between 30.4 and 39.5 per cent were admitted from home and discharged to a care home (FOI request, 2015 – response from 65 trusts). These incidents are not only potentially catastrophic for people with dementia and their families but waste millions of pounds. In 2013/14, it was estimated that emergency readmissions cost the NHS £93 million (CHKS, 2015). A simple way for hospitals to be more transparent and accountable is by publishing a yearly dementia statement. This statement might include: the number of inappropriate discharges, including those between the hours 11pm and 6am, with less than 24 hours' notice or with significant delays the number of emergency readmissions within 30 days the number of people who receive an appropriate assessment of health and wellbeing on arrival at hospital

				A CQC review in 2012/13 concluded that people with dementia have poorer outcomes than other similarly aged population groups. They found that the number of patients with dementia who died in hospital was more than a third higher (36%) than similar patients who did not have dementia.
2	Alzheimer's Society	General	General	The suggested Measures for the Quality Standards fail to fully recognise the unique experience of hospital admission for people living with dementia. Currently it is unclear how the personal experiences of people with dementia will be gathered and used.
3	College of Occupational Therapists	General comment	General	I would want to see a QS that gives a clearer guide for professionals working relationships and processes between hospital and community settings in order to ensure good transition. If further QS is not possible then perhaps an expansion / more detailed explanation of the Discharge Coordinator role. Throughout the guidance this is seen as a key link with community based MDT. They can; Share assessments / updates to community team during the stay. Liaise about equipment needs for example in timely way to prevent delay and promote successful discharge. Get agreed plan from community teams. Ensure effective working relationships across services. This is key to prevent readmission and something which was highlighted in the recent ombudsman report. Related parts of guidance. ***1.3.8 The hospital-based multidisciplinary team should work with the community-based multidisciplinary team to provide coordinated support for older people, from hospital admission through to their discharge home.*** ***1.5.5 During discharge planning, the discharge coordinator should share assessments and updates on the person's health status, including medicines information, with both the hospital- and community-based multidisciplinary teams.*** ***1.5.18 The discharge coordinator should discuss the need for any specialist equipment and support with primary health, community health, social care and housing practitioners as soon as discharge planning starts. This includes housing adaptations. Ensure that any essential specialist equipment and support is in place at the point of discharge.*** ***1.5.19 Once assessment for discharge is complete, the discharge coordinator should agree the plan for ongoing treatment and support with the community-based multidisciplinary team.*** **People at risk of hospital readmission**

				1.5.27 The discharge coordinator should refer people at risk of hospital readmission to the relevant community-based health and social care practitioners before they are discharged. It Is suggested that there should be a link between this quality standard and those on Falls Prevention and Dementia, so that they are not looked at in isolation. They are referenced at the end of the draft but we would suggest that the link be made explicit within the standard. The standard does not reference the National Audit of Intermediate Care the content of which overlaps with this Quality Standard i.e. facilitating timely discharge from hospital, preventing unnecessary hospital admissions, monitoring the number of readmissions within 91 days.
4	Healthwatch Bristol		General	Healthwatch Bristol receive many comments about discharge processes and the biggest issues appear to be the joining up of services in the community and the delays this cause or the problems encountered when they haven't been set up properly.
5	Healthwatch Essex	General comments on the draft consultation	General	1. Although the questions that have been included in this consultation document are important for assessing the (cost) effectiveness and feasibility of implementing the quality statements, we believe that they fail to adequately capture the complexity of the mechanisms that will allow these statements to be successfully and systematically executed by the local health and social care services. Our research has indicated that there is a range of complex mechanisms that often influence transitions of care (i.e. communication problems, training of staff on discharge planning). These mechanisms often play an important role in care transitions, and therefore healthcare policy makers and professionals should take them into account when developing quality statements. 2. Although the development of quality statements is an important step towards ensuring quality in care transitions, we believe that the consultation document needs to illustrate how these quality statements inform and relate to each other, to ensure that they contribute to improving patient experience of (post)-discharge related care and smooth care transition.
6	Hospice UK (formerly Help the Hospices)	General	General	The tone and focus of the quality standard is that the person is moving on to a recovery or enabling phase. Many of this population will be approaching the end of life, and would benefit from a supportive or palliative care approach. Admission and discharge from hospital should be a trigger for advance care planning. It would be helpful if this was reflected in the standards.
7	MHA (Methodist Homes)	General	General	From the perspective of older people, the standards in this draft really need to be achieved. If they are followed it would seem likely that avoidable/repeat hospital admissions would be greatly reduced. Emphasis needs to be on hospitals and the community/ care home settings working together.

8	NHS England	Page5	General	The outcomes framework needs to reflect the newest NHS Outcomes Framework 2016/2017
9	East Midlands Academic Health Science Network on behalf of the Patient Safety Collaborative Discharge cluster		General	We agree with all the standards and information presented.
10	LondonADASS		General	The main aim of LondonADASS is to improve social care across London, and to identify ways of doing this more cost-effectively. We do this by working with staff in Adult Social Services across London and with other bodies, such as NHS England, which are involved with the health and wellbeing of Londoners. We encourage collaboration through a number of networks and projects focussed on particular topics. The draft quality standards were sent to the following networks and asked for feedback as requested in this form: Continuing Healthcare (62 members) Commissioning Leads (80 members) Dementia (60 members) Delayed Transfers of Care (53 members) Strategic Performance Leads (54 members) End of Life Care Leads (43 members)
11	LondonADASS	Introduction	General	The introduction is mainly appropriate though it would benefit from also including reference to the Care Act (2014). The Care Act (2014) discusses adults who require care and support, not those who have social care needs. The wording has changed. The Care Act: assessment and eligibility - "*The eligibility threshold for adults with care and support needs is based on identifying how a person's needs affect their ability to achieve relevant outcomes, and how this impacts on their wellbeing*." Local authorities must consider whether the person's needs:

				Arise from or are related to a physical or mental impairment or illness Make them unable to achieve two or more specified outcomes As a result of being unable to meet these outcomes, there is likely to be a significant impact on the adult's wellbeing Additionally greater clarity is needed to ensure that the social care needs are related to discharge arrangements and not to admissions as the document appears to suggest in the first paragraph.
12	LondonADASS	Why this quality standard is needed	General	We are mainly in agreement with this section but note the following: Poor transitions also include when families/carers are unhappy about and/or dispute the proposed after-care arrangements and therefore unwilling to support the discharge Additionally the completed health needs assessment may not be robust enough resulting in delays due the multidisciplinary teams being unable to make a recommendation
13	LondonADASS	Quality Standards Advisory Committee	General	It is disappointing to note the low representation of the social care, independent and private care sectors.
14	LondonADASS	IT systems	General	Need for adult social care and NHS systems to be joined up to facilitate the sharing of information
15	LondonADASS	Engagement with CCGs	General	Many of the tasks down to clinical commissioning groups will be the responsibility of the CCG leads for acute services and I just wonder whether they will be (or have already been) consulted with prior to the statement being published
16	Nutricia: Advanced Medical Nutrition	Statement 5	general	The draft quality standards do not currently reflect the key areas for quality improvement as relevant as patient and carer concern regarding nutrition is little understood. Carers UK indicate that over half of carers are concerned about the nutrition of the person that they care for. However, despite evidence, NICE Clinical Guidance, Quality Standards and disease specific pathways such as COPD and Stroke, medical nutrition as an integral mechanism of health management is not prioritised by policy makers, payers and healthcare professionals. There appears to be significant inconsistency in the application of nutrition across the NHS; and between diseases and conditions. We suggest that best practice would be to educate health care professionals, statutory bodies and policy makers on the benefits that medical nutrition can bring to those suffering from a range of ill health. Medical nutrition should be used in addition to and separate from dietary interventions associated with public health or more general health campaigns. The management through medical nutrition of co-morbidities can improve the lives of patients greatly and improve their lives and

				general wellbeing considerably. The Care Act 2014 states nutrition being important as part of health and well-being and the needs of the individual carer should be taken into consideration.
17	Alzheimer's Society	General	General	There are around 850,000 people in the UK living with dementia (Prince et al, 2014), with over 42,000 developing the condition before they reach 65. Nearly all people living with dementia will require care and support from both the NHS and social care system at some point as a result of dementia having features of neurological disease, mental illness and physical frailty that cross the boundaries of the health and social care system. In addition, Research indicates that around 70% of people with dementia live with co-morbidities, (Alzheimer's Society, 2015). Time in hospital often has a negative effect on the health and wellbeing of people with dementia; any delays in discharge can cause further deterioration. However, being discharged prematurely, following poor care or without the adequate community support in place, can lead to someone becoming ill or falling and being readmitted to hospital, often in a worse condition than before. Hospitals can be loud and unfamiliar, and the person may not understand where they are or why they are there. It can also lead to people being discharged to a care home despite research showing that 85 per cent of people with dementia want to be supported to live in their own home throughout their condition (Alzheimer's Society and YouGov, 2014).
18	Royal College of Physicians	General	General	The RCP are grateful for the opportunity to respond to the above consultation. We would like to draw your attention to the Future Hospital Programme. Although we cannot currently release any data, we would like to update you on the following. The Royal College of Physicians' (RCP) flagship Future Hospital Programme was set up in 2014 to realise the recommendations of the Future Hospital Commission report which laid out 11 core principles of patient care[30]. The Future Hospital Programme supports eight frontline development projects in Trusts across England and Wales which are committed to improving, designing and delivering medical care that meets the current and future needs of patients. The projects are an exploration of the ways in which clinical teams can

				adapt the system to deliver person centered care for the benefit of their patients’ health outcomes and experience. Our phase one sites at East Lancashire Hospitals NHS Trust, and Mid Yorkshire Hospitals NHS Trust work directly with frail older patients to improve and standardise the ‘front door’ experience. The clinical teams are also joining up with specialised healthcare professionals in the community so that the patient journey is streamlined and coordinated. We believe this is benefitting patients because they are receiving earlier assessments by senior doctors, their patient pathway is built on individual needs, , and their transfer from hospital is quicker and effectively supported. The project team at Mid Yorkshire have established a Rapid Elderly Assessment Care Team which is made up of consultants, specialist nurses and therapists who collectively assess and treat patients to enable them to be fit to leave hospital as soon as possible. The multidisciplinary team meet every morning to discuss each patient’s progress and this enables them to treat patients in a holistic way as they can offer patients access to both the health and therapeutic services they need. Comparing data from 2014 to 2015, the team have achieved a 24% increase in the number of patients aged 80 and over being discharged from the acute assessment unit rather than moving to a base ward. East Lancashire Hospitals NHS Trust have created Integrated Neighbourhood Teams (INTs) which bring together doctors, nurses and therapists, including rehabilitation and support staff into multi-disciplinary teams. They serve a population of approximately 30,000 people who are registered with neighbouring GP practices. The teams are dedicated to working alongside frontline hospital doctors and GP practices to integrate healthcare for patients and prevent extended stays in hospital. A key component of the team operating in East Lancashire is that they meet regularly to identify high risk patients who require more support and a tailored pathway plan. Work is now progressing to include mental health care workers, and voluntary sector professionals in the INTs. The Intensive Home Support Service (IHSS) also operating in East Lancashire is a rapid response - 2 hours from referral 7.30am to 10pm, 7 days per week – multi-professional service to prevent unnecessary hospitalisation or conveyance to the emergency department. The multi-professional health and social care service is strengthening community services to provide managed transfer back home or into community services, as well as reducing hospital admission. Keeping people closer to home is helping to maintain their independence. The team has seen early reductions in average length of stay and seven-day readmission rates. In summary, the Future Hospital Programme is striving for and achieving best practice for frail older patients across their patient pathway through bespoke services at the front door, and through integrating primary and secondary healthcare.

19	Royal College of General Practitioners	General	General	This all seems sensible, and likely to have the desired effect in improving the experience of those with social care admitted to hospital. The RCGP feels that it is likely to improve good practice, especially around assessment by a geriatrician, and the statements around discharge. The document indicates that problems occur and makes general recommendations which are admirable around better communication, a tailored plan, carer involvement etc. It would be helpful to examine the problems by age group-at least < 60 and > 60 as the nature of the problems, their chronicity and support mechanisms are likely to be different and increasing other morbidity with age. The nature of the admission i.e. planned or emergency and whether it is a regular event for long term conditions is worth exploring too. A planned admission can have an agreed treatment and discharge plan in advance. Day hospitals may be a useful bridge in the care pathway. The provision of aids and adaptations to enable discharge are as important as medication and social support. The need for follow up care by hospital or GP needs to be agreed in advance and also provision for timely help and advice, sometimes with a “hot-line” after discharge.
20	Action on Hearing Loss	General	General	Action on Hearing Loss, formerly RNID, is the UK’s largest charity working for people with deafness, hearing loss and tinnitus. Our vision is of a world where deafness, hearing loss and tinnitus do not limit or label people and where people value and look after their hearing. We help people confronting deafness, tinnitus and hearing loss to live the life they choose, enabling them to take control of their lives and removing the barriers in their way. We give people support and care; develop technology and treatments and campaign for equality.

				Our response will focus on key issues that relate to people with hearing loss. Throughout this response we use the term 'people with hearing loss' to refer to people with all levels of hearing loss, including people who are profoundly deaf.
21	Action on Hearing Loss	Diversity, equality and language	General	The importance placed on meeting communication needs throughout the draft quality standard, as demonstrated in this section, is good. We would like to suggest a small change in wording to emphasise the need for both good communication and accessible information, as both are very important for ensuring people can participate in the planning and delivery of their care. Suggested amends: '*Treatment, care and support, and the information given about it, should be culturally appropriate* ***and the person receiving care should be as involved as possible in the planning and delivery of their care. Information should be*** *accessible to people with additional needs…do not speak or read English,* ***and any communication needs should be met. This includes adults*** *with social care needs…****having*** *an interpreter or advocate made available if needed.'*
22	Action on Hearing Loss	Policy context	General	The Accessible Information Standard should be added to the policy documents listed in this section. NHS England's Accessible Information Standard: https://www.england.nhs.uk/wp-content/uploads/2015/07/access-info-spec-fin.pdf
23	Action on Hearing Loss	Related NICE quality standards	General	**Add the following quality standard (in development) to the list of related NICE quality standards:** **Mental wellbeing and independence for older people** NICE in development [GID-QS10008]Expected publication date: December 2016
24	Headway – the brain injury association	Related NICE quality standards	General	We would suggest including the NICE Head injury: assessment and early management (CG176) guideline here
25	Healthwatch Bristol	Role of family members and carers	General	Healthwatch Bristol continue to hear poor experiences from carers of both adults and as parents regarding 'professionals' not involving them in the decision making and not listening to their concerns to the detriment of the patient.
26	OPAAL UK	Diversity, equality & language	General	OPAAL is happy to see advocacy mentioned but has concerns around who makes the judgement on advocacy being "needed" (Adults with social care needs transitioning between hospital and the community or a care home should have an interpreter or advocate made available if needed.) We feel that there should be good training about advocacy for discharge coordinators as mentioned in comment 2 above and there should be clear guidelines about when advocacy should be considered.

27	Action on Hearing Loss	General	Question 1	General comments and response to question 1) Does this draft quality standard accurately reflect the key areas for quality improvement? Action on Hearing Loss welcomes the opportunity to comment on the Transition between inpatient hospital settings and community or care home settings for adults with social care needs draft quality standard. Poor transitions planning can lead to inappropriate care and deterioration in health and wellbeing. To prevent avoidable admissions to hospital, health and social care services should work together to make sure adults with social care needs get the support they need in community and care homes settings. Diagnosing and managing hearing loss and taking hearing loss into account during the diagnosis and management of other conditions is crucial for good communication and care. We believe the current draft of quality standard does not fully recognise the personal and social impact of hearing loss. Hearing loss is a long-term condition affecting over 11 million people in the UK – one in six of the population. As our society ages this number is set to grow and by 2035 more than 15.6million people in the UK are predicted to have a hearing loss. Hearing loss is the most widespread long-term condition among older people, experienced by almost three quarters (71%) of all people over 70 years[1]. Many older people transitioning between inpatient hospital settings and community or care home settings are likely to have a degree of addressed or unaddressed hearing loss. People with hearing loss may find it more difficult to communicate with friends, family and health and social care professionals and have an increased risk of developing other health problems. Evidence summarised in our Hearing Matters report[2], demonstrates the susceptibility of people with hearing loss to social isolation, depression and also cognitive decline and the development of dementia. Hearing aids can help reduce these risks but many people are waiting too long to get their hearing tested. Research shows that people wait on average ten years before seeking help and that when they eventually do, GPs fail to refer up to 45% people with hearing loss for a hearing assessment[3]. Hearing aids are also most effective when fitted early, and people with severe hearing loss find it more difficult to adapt to hearing aids[4]. Early diagnosis is crucial to prevent worsening health and wellbeing. Research by DCAL and Action on Hearing Loss research, shows that up to £28 million could be saved by properly managing hearing loss in people with dementia and delaying admission into costly residential care. It is important that health and social care professionals at all points of a care pathway are identifying people with hearing loss and encouraging them to seek support (in line with NICE's quality standard for the mental wellbeing of older people in care homes[5]. Health and social care professionals should also be actively signposting people to other relevant services as part of the care transition process. Often people are relying on health and social care professionals for information on what support is available; for example under the Care Act 2014, local authorities must provide community equipment up to the value of £1000 which can help people live safely and independently, and

				local authorities and housing providers also have separate duties under the Equality Act 2010 to make reasonable adjustments for people who have substantial difficulty accessing their services, but people often aren't aware of these duties. We therefore think the signposting role health and social care professionals need to play during the transition process should be increased throughout the quality standard, including the need for them actively to identify adults who have social care needs but who aren't currently accessing support. This will improve the smoothness of the transition process and also prevent avoidable readmission into hospital. People with hearing loss may also need support to communicate well and participate fully in the discharge planning process. Given this, Action on Hearing Loss is particularly pleased to see references at points throughout this draft quality standard to ensuring communication and information needs are met, and we recommend strengthening these sections. It is imperative that processes are always in place to meet communication and information needs throughout the care transition in order for people to be able to understand what will happen when they leave hospital and to allow them to participate in the discharge planning process. The Accessible Information Standard[6], which becomes mandatory from 31st July 2016, requires all NHS and adult social care providers to have systems in place to identify, record, flag, share and meet communication needs of people with disabilities and sensory loss, which includes providing accessible information, communication support, and creating an environment where good communication can take place. The Standard provides extensive guidance for NHS and social care providers and it should be promoted in more detail alongside all the relevant quality statements. In summary, the quality standard must make reference to the following: The importance of signposting people to services and support during the transition process that can help reduce the likelihood of avoidable readmission to hospital. This includes identifying people who have an unaddressed hearing loss and also helping people navigate the social care system where they can see there is more support they would benefit from. The requirements of the Accessible Information Standard – health and social care services must meet the communication and information needs of people with hearing loss during the transitions process to make sure they are fully involved in discussions about their care.

28	MHA (Methodist Homes)	General: Does this draft quality standard accurately reflect the key areas for quality improvement?	Question 1	We agree that the draft quality standard accurately reflects the key areas for quality improvement. However we do think that there is very little reference to care home providers and their key role in ensuring a smooth discharge from hospital, to a care home setting. We understand this covers both community settings and care home settings, but we feel more acknowledgement of the responsibilities care homes have is required and should be included in the list under 'What the quality statement means for service providers etc'. We feel this would help us as a provider ensure we aim for and achieve our responsibilities in this process.
29	OPAAL UK	Question 1	Question 1	OPAAL believes that this draft quality standard does accurately reflect the key areas for quality improvement. It does not however, contain sufficient tangible information provision about the use and benefits of independent advocacy. We have concerns that several of the provisions in the standards will become tick box exercises not fully engaging the person being discharged.
30	Parkinson's UK	Does this draft quality standard accurately reflect the key areas for quality improvement?	Question 1	We broadly agree that the draft quality standard reflects the key areas for quality improvement. However, we are disappointed that the quality statements do not go further, to provide more specific information about what 'contingency plans' should include, for example requiring health and social care professionals to support their completion. We are also disappointed that the draft quality standard makes no mention of medicine self-administration policies or NHS Continuing Health Care which can make a crucial difference between a timely and delayed discharge from hospital for people with Parkinson's. We note, for example, the recent report from the Parliamentary and Health Service Ombudsman[15] which identified failures to check people's mental capacity and offer legal protections for those who lack capacity, carers and relatives not being treated as partners in discharge planning and poor co-ordination within and between services
31	Royal College of General Practitioners	**Question 1**	Question 1	This standard does clearly reflect the key areas for improvement.

32	MHA (Methodist Homes)	General: If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?	Question 2	We are unable to comment on the data collection methods.
33	Parkinson's UK	If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?	Question 2	Yes, although the degree to which the first quality measure – which requires contingency plans to have been completed is difficult to quantify, as health and social care professionals may not ask them unless they are needed.

34	Royal College of General Practitioners	**Question 2**	Question 2	Local systems are not currently in place. The pressure under which acute hospitals are working means that discharges and admissions are currently being undertaken under a massive pressure .Patients are often discharged without any discharge medication at all and without any proper discharge planning. Trying to move from this chaotic situation to one of data collection without any investment in basic infrastructure will divert more resource away from the delivery of the basic process.
35	MHA (Methodist Homes)	General: Do you have an example from practice of implementing the NICE guideline that underpins this quality standard?	Question 3	Based on experiences in MHA care homes, below is an outline of key risks we feel should inform the standard: Areas of risk include critical information that prevents error (the arrival into a new setting is potentially fraught with risk if accurate information is not shared both verbally and backed up in written form). passing on information regarding current medicines prescription and having a supply of medicines so that there is no delay in administering critical medicines tissue viability - information is critical pre discharge so that suitable equipment and staff support can be made available in advance barriers to communication (cognitive impairment or, for example hearing impairment) need to be shared in advance so that a suitable support plan can be agreed to overcome these barriers complex needs need to be shared so that the community setting is prepared to meet needs (sometimes community settings can adapt to people with complex needs if given time to risk assess and then put actions in place to overcome these risks e.g. training and competency assessment of staff or hiring of specialist equipment) It is critical that staff who are organising a placement into a home understand the capabilities of the home so that choices are made based on ability to deliver safe care (there are sometimes issues of honesty in terms of the needs of the patient which results in people being placed into a home that cannot safely support a person's complex needs).
36	OPAAL UK	Question 4	Question 4	OPAAL has concerns that current net resources will be insufficient. It is essential if these outcomes are to be achieved that resources are moved to prevention, which we believe is what these statements encompass. It's likely there will need to be investment in delivery of these statements before the resultant cost savings can be made through a reduction in admissions.
37	Royal College of General Practitioners	**Question 4**	Question 4	Some statements in this draft quality standard wouldn't be achievable by local services given the net resources needed to deliver them. There are inadequate resources to add a further layer of planning onto an already stretched admissions and discharge process .Although the guidance describes an ideal situation, realistically there are few resources to implement this and with the health and social care economy already running at a historically low percentage of GDP there are unlikely to be resources to be liberated through disinvestment. It may be possible to use a unified discharge medication sheet for ward doctors and pharmacists to use which can then be given to the patient. (JD)

38	Action on Hearing Loss	Rationale (page 11)	1	*'It can also allow for other aspects of the person's life to continue as normal, such as arrangements at home.'* We feel this should be amended to read *'to be as unaffected as possible, for example arrangements at home',* because it would probably be difficult for aspects of life to continue as normal if someone is admitted to hospital.
39	Action on Hearing Loss	What the quality statement means for patients, service users and carers (page 12)	1	Reference should be added at the end of this section to the need for the plan also to be *'developed and shared with family or carers, where appropriate'* in line with the best practice outlined in the overarching principles of the corresponding NICE guideline to these Quality Standards.
40	Action on Hearing Loss	End of section	1	The Equality and Diversity Considerations paragraph on barriers to communication and understanding information, used in the sections about quality statements 3 and 4, should be added to quality statement 1 too, because good communication and the ability to understand information is key to producing an effective plan.
41	Alzheimer's Society	Statement 1	1	We believe that for noticeable quality improvement, this Statement would need to include many people who are in need of support, but who do not meet strict eligibility criteria for social care services. Many people are living with support needs but receive no services, and will be at risk of deteriorating to a point where extensive services or residential care is needed if admission to hospital is required.
42	Care and Repair England	Statement 1 contingency plan	1	It would be helpful to include a template of what a good contingency plan should contain to support this quality standard. This would ensure that the plan covers all aspects of a person's care including their housing and housing support needs. It would also be helpful to ensure that agreement is reached locally on who is responsible for ensuring that the plans are developed for each eligible person.

43	College of Occupational Therapists	Adults with social care needs who are at risk of admission to hospital have a contingency plan for hospital admission.	1	This is a key area for improvement. Development of care passports would assist with this. Also, protocols on data sharing and shared / integrated IT systems would aid collection of data and improve the experience for the person. A simple ideas like the Sutton CCGs ‘red bag’ is an innovative approach. http://www.wired-gov.net/wg/news.nsf/articles/In+the+bag+making+moving+between+hospital+and+social+care+better+12052016091500
44	Department of Health	Statement 1 (Outcome measure 1A, 1B and 1D)	1	It would be helpful to clarify how these outcome measures will inform this Quality Statement.
45	Headway – the brain injury association	Statement 1 (What the quality statement means for patients, service users and carers)	1	We would suggest also having the written care plan for adults with social care needs available to family and carers as well as the hospital team.

46	Healthwatch Essex	Q.4	1	Even though we believe that the development of a contingency plan for hospital admission can contribute to improving patients' experience of care, we contend that staff shortages within the local social care and secondary care settings can create obstacles in delivering this quality statement. We contend that social care and hospital staff will play an important role in the development and execution of the contingency plan; our main concerns are the following: 1) who is going to lead to the development of the contingency plan, 2) it is unclear how this plan will be shared between health (including primary and secondary care services) and social care services, and 3) there is a lacking clarity who is responsible for executing the plan. Although we do not possess the skills and knowledge to break down the costs involved in the implementation and delivery of this statement, based on our findings, we believe that local health and social services need to recruit more staff in order to deliver this quality statement.
47	Hospice UK (formerly Help the Hospices)	Statement 1 (structure)	1	The statement that adults with social care needs who are at risk of admission to hospital should have a contingency plan for hospital admission would suggest that all care home residents, and many people receiving social care in their own homes, should have such a plan. Is this workable?
48	Hospice UK (formerly Help the Hospices)	Statement 1 (process)	1	It might also be worth including the proportion of people approaching the end of life, and who will have been entered on to an electronic palliative care coordination system locally, who should also have a contingency plan for hospital admission.
49	Independent Age	Statement 1 – Measure	1	The contingency plan should make clear who is responsible for informing other organisations, notably the local authority or Department for Work and Pensions, of the admission and subsequent consequences.
50	MHA (Methodist Homes)	Statement 1	1	Having just reviewed the draft 'Quality Standard for Older people with social care needs and multiple long-term conditions'', it would be useful to have cross-referenced to health and social care plans and ensure that hospital settings have sight of health and social care plans on admission, as part of a comprehensive older persons assessment.
51	National Housing Federation	Planning for Admission	1	Traditionally, housing associations have developed models of hospital discharge support, which sit alongside hospital reablement teams or operate independently to provide care and support to enable someone to return home quickly after time in hospital. Housing associations know that enabling older people to return home safely from hospital is not only about efficient transfer of medical and social care; faster discharge and reduced re-admissions may also require changes to older people's housing and living situations in the community. There is a already a growing evidence based but more work in required to develop a measure which provides incentives for the NHS to commission housing associations

52	NHS England	Statement 1 Rationale	1	Implementation of this statement requires clear and consistent early identification of the at-risk population and clear anticipation of the likely reasons for admission and events which derive from their admission. Even for people with clearly defined conditions the sequence of events in hospital is not always possible to anticipate in ways which are easy to articulate in a care plan. In the main this process will therefore default to negative statements (such as ceilings of care statements or avoidance of admission in the first place) rather than person centred preferences for care delivery if anfd when they are admitted. The latter outcomes are often a product of the processes which occur at admission and beyond the control of both patients and those who are undertaking the process of care planning. Traditional risk stratification approaches tend to select out patients with multiple co-morbidities and conditions who tend to be frequent service users. For many of these people they may have already had experience of hospital admission. Triggering of revised care planning following such an event may improve their subsequent experiences but the timing of and provider ownership/responsibility for this may be difficult to align with other events related to the preceding hospital discharge and recovery. This is particularly the case when there is a prolonged recovery phase during which time the person’s condition may fluctuate if they have delirium or advanced frailty state. In addition for patients with poorly identified conditions such as frailty, delirium and sub-clinical dementia there may be no opportunity to trigger care planning prior to hospital admission as it requires the person to be identified as being at risk in the first place and traditional risk stratification approaches may not be able to do this currently. There is also an assumption in the statement that helping a person to know what to expect will improve their experience. This may not be the case as their experience will be a combination of both their reasons for requiring hospital care, treatment received and outcomes. None of these things are easy to build into a care plan even though they may be anticipated.
53	NHS England	Statement 1 Process	1	For the numerator this may be relatively easy to identify if there is clearly identified process in place for contingency planning and storage. Given that for many community systems this may still be paper based and non-standardised there may however be problems collecting meaningful data. The denominator may be not capture the population who are truly likely to benefit from implementation of this standard – see comments above.
54	NHS England	Statement 1 Outcome	1	The outcomes stated here are linked to the process of contingency planning not the ‘experience of hospital’ as stated in the rationale. Consideration should be given to alignment of the rationale with the outcomes being measured if the statement is to truly drive better patient centred hospital experience outcomes.

55	Nutricia: Advanced Medical Nutrition	Statement 1	1	This draft quality statement does reflect the key areas for quality improvement with adults with social care. In relation to question 4, local services can achieve these quality standards if out of hospital care nursing services are provided. This may be simply a change in the way funding is allocated. Though local services are stretched and net services would not be able to cover all ground, Nutricia does provide resources that will be of help to local authorities, trusts, CCGs and carers.
56	Parkinson’s UK		1	Although Parkinson’s UK agrees with the principle of contingency planning for hospital admission, we are disappointed that the draft Quality Standard places the onus on an individual with social care needs to develop their own plan, with no requirement for this to be created in collaboration with either health, or social care professionals. We note that the Care Act already stipulates, what should be included in a care plan, for example[16]. Parkinson’s is an extremely complex condition, with over 40 motor and non-motor symptoms, including tremor, confusion, depression, anxiety, freezing and problems with speech and swallowing. Given that Parkinson’s is degenerative, it is likely that someone with the condition will be admitted to hospital , for a period of time. For this reason, anticipating an admission to hospital is helpful, particularly in cases of advanced Parkinson’s, where an individual may lack mental capacity as a result of dementia related symptoms. However, we believe that a contingency plan should always be co-developed with health and social care professionals wherever possible, this would ensure that the plan has the support of staff concerned with an individual’s care, who may be able to communicate key details to staff in the hospital setting prior to admission. It is also of critical importance that the contingency plan is agreed with an individual’s carer as well, as they will have an intimate understanding of the condition, as well as the medicines management routine. We discuss this further below. A carer of a person with Parkinson’s explains: ‘Throughout the many years I have been my husband’s carer, the progression in severity and complexity of his various health conditions, (in which Parkinson's is a major player), has meant my caring role has had to alter and adapt to his ever increasing needs. All aspects of his wellbeing and safety rest squarely with me. Knowing him as well as I do affords me the right to speak on his behalf when he can not, conveying to doctors & health care professionals an accurate & comprehensive picture of his physical and mental states, as observed by me.’

				Recommendation: That the Quality Standard emphasises that the plan should be developed in collaboration with family members, and health and social care professionals
57	Parkinson’s UK		1	We are disappointed that the draft Quality Standard does not specify what should be included in any contingency plan, such as whether a person has mental capacity, an up-to-date list of the medications they are taking, whether they are able to self-medicate and all of their main health conditions and symptoms. We do not believe it is sufficient for the guideline to stipulate that an individual should develop one, particularly if no advice is given on the type of information that is relevant for hospital staff, or places any requirements on health and social care professionals to assist in its development. Parkinson’s UK believes that self-administration of medication should be included in any contingency planning document, as this will enable people to receive their medication in a timely manner and could prevent their condition from worsening unnecessarily. Ascertaining the ability of a person with Parkinson’s to self-administer their medication in hospitals and care homes is essential to ensure those who are able can maintain their complex medication regime. A person with the condition explains: *‘My walking suffered a lot without getting my tablets on time especially as I was rather weak anyway. Nurses started asking "Why can't you walk, what's wrong with your legs?" So having the meds myself saved time’*. The NICE Clinical Guideline on Parkinson’s* includes a specific reference to the importance of getting medication on time and self-administration policies. The guideline, which is currently under review by NICE,

				specifically states medication should be *'given at the appropriate times, which in some cases may mean allowing self-medication.'* A 2013 YouGov survey** completed by 4,777 people who have either been diagnosed with the condition or are family members or carers of people with Parkinson's, found that of those having been in hospital or a care home, 30 per cent reported not receiving their medication on time. In order to gain an insight in to the practice of self-administration across the UK, Parkinson's UK sent Freedom of Information requests in October 2013 to 181 Trusts and health boards for information on the existence of an organisational self-administration policy and whether they were being actively utilised. Out of the 88% of trusts and boards that responded, 17% of trusts/boards reported they did not have a self-administration policy in place. However, it was harder to ascertain the level and quality of implementation through the requests. Having NICE guidelines in place which recommend the active implementation of self-administration policies will play an important part in improving provision and ensuring a smooth transition between inpatient hospital settings and community or care home settings for adults with social care needs. **Recommendation:** The Quality Standard includes contingency plan among the 'definition of terms used in this quality statement' section. This should set out examples of the kind of information that should be included in a contingency plan, including medicines management and self-administration. *NICE, CG35, *Parkinson's disease in over 20s: diagnosis and management, 2006* ** Parkinson's UK and YouGov, *Survey of people with Parkinson's and their friends, family and carers*, 2013 *** Parkinson's UK, *Getting Parkinson's medication on time*, 2012.
58	Shared Lives Plus	Statement 1	1	Involving discharge planning prior to admission for those at most risk could support a smooth discharge for those who have frequent admissions to hospital. We welcome the statement but believe it's important that the person involved and family and other carers are fully involved in drawing up the contingency plan and that it reflects realistic expectation.

59	Guys & St Thomas NHS Foundation Trust	Question 1	1	It isn't entirely clear what is meant by 'contingency plan for admission' – It appears to mean that plans in place to ensure admission to hospital is smooth (including maintaining arrangements at home, better communication between community and hospital and helping them know what to expect on admission) but it could also be interpreted as a plan for an alternative to admission to hospital. Plans that support improved communication between settings is very useful. Plans to detail what to expect would be difficult for non-elective admissions but should be a standard for elective admissions. The outcome would be better phrased "patients have a better experience of hospital admissions rather than "peoples experience of planning admission"
60	Guys & St Thomas NHS Foundation Trust	Question 2	1	Presumably relies on Social Services/GP/community systems having this data available. Limited opportunity to capture this via in-hospital systems.
61	Guys & St Thomas NHS Foundation Trust	Question 3	1	Would need answer from community/Social Services/GP on this
62	Guys & St Thomas NHS Foundation Trust	Question 4	1	Unsure – again need answer from community/Social Services/GP on this
63	Royal College of General Practitioners	Statement 1	1	On the face of it this is a sensible ambition. However it is now clear that there are considerable difficulties with risk stratification. Hospital admission is essentially unpredictable, so that any instrument that does include everyone at risk finishes up identifying a lot of patients who overall have a very low risk of admission. This may make worse by giving GPs a target percentage of patients to create the denominator. That in turn meant two things. In order to reach the threshold GPs have to include not only those whom at risk, but many more in addition who should not be consider at risk of admission. Inflating the denominator in this way then meant that the planning became a superficial, hurried exercise of box ticking. When it was very clear that in some circumstances it could be useful. For instance in the patients in a nursing home where admission was sometimes avoided by consulting the previously created planning document. (DJ) This statement will be exceptionally hard to implement if it relies on the contingency plans being drawn up via GP services .There is no capacity in primary care to undertake what is likely to be a very large corpus of work given the numbers of adults with social care needs. A blanket approach which relies on primary care to undertake this work is likely to result in perfunctory and unusable plans.

				It would be more appropriate that this work would rest with those who have direct knowledge of the individuals day to day care requirements e.g. social care providers and family members, with medical input only if required. (JD)
64	LondonADASS	Quality statement 1	1	We are mainly in agreement with this statement but note the following: The information is not currently systematically collected and stored; therefore, there will need to be system developments for the storage of data, with new plans being created when necessary. This may become a tool used in the cases where there are multiple hospital admissions over a short-time frame. It would be more difficult to develop plans for clients who have settled long-term services, where there is no indication of health issues that require hospital admission at the review stage. Residential/care homes may have plans which are not held on the council's system and can be put into action without the council's knowledge. One area currently has a system whereby clients are asked to leave this information on a fridge/freezer, but it has been noted this information soon becomes out-dated. There is a real requirement to ensure this information remains current. There needs to be an increased focus on communication – local feedback has noted that clients may be admitted several times to different hospitals. Recommendations do not follow patients and get lost between one admission and another. Recommencement of care packages are requested without consideration of admission history. Care and support needs - this can include those who have a complex PEG. In these cases carers would be working alongside the district nurses to manage the PEG or a catheter; the carers would empty it but not change it. By saying 'social care needs' this may result in the medical side being excluded. Therefore the Care Act 2014 wording needs to be applied. Need to consider the impact on care organisations that have been providing care to the individual prior to the admission. What mechanisms can be in place to retain consistency taking into account the financial challenges currently faced by local authorities Could also include service user self defined quality of life metrics From an End of Life Care perspective, the Electronic Palliative Care Co-ordination Systems (EPaCCS) system should be mentioned and that it needs to be accessible by hospital and community services to prevent, expedite or ensure short admissions, as appropriate.

65	LondonADASS	Quality statement 1 (measure)	1	Several issues have been raised in relation to the ease of collecting this data. These include: Adults with social care needs can be admitted for other medical reasons besides the lack of a contingency plan. In order for this to work there must be a robust response within the community that can support people with various medical needs in the community. Adults with social care needs very rarely get admitted to hospital due to a breakdown of care packages - social admissions are very low. Risk Stratification systems in primary care do not always include social care needs. This is not a current requirement of registered care providers so it is not clear how this can be gathered currently. For people known to social care in their own homes where there is a carer who has elected to have an assessment, local areas have contingency plans for breakdown but do not routinely have this for all service users.
66	Action on Hearing Loss	Rationale (page 14)	2	We feel there should be an addition to this paragraph to highlight the benefits of carrying out a comprehensive geriatric assessment for someone's time in hospital care as well as afterwards: *'Identifying these, by using a comprehensive assessment, allows practitioners to develop a long-term plan to manage their needs <u>and understand how best to care for someone while they are in hospital.</u> This…'* It is important to make this clear as overlooking people's needs can have an adverse impact on the effectiveness of their treatment and health outcomes. For people with hearing loss inaccessible services can lead to missed appointments and confusion over diagnosis and treatment. Our research has shown when visiting the GP, more than a quarter (28%) of people with hearing loss did not understand their diagnosis, and one in five (19%) were unsure about their medication[7], and we've also found that the communication needs of people who access social care are routinely overlooked[8]. For people who are profoundly deaf, research in 2012 showed that even when a BSL interpreter is requested, around two-thirds of BSL users (68%) don't get one; and almost half of those who do find the quality of interpretation isn't good enough[9]. It is vital that needs like this are assessed and addressed so that people with hearing loss can communicate well and receive effective treatment.
67	Action on Hearing Loss	Rationale (page 14)	2	It could be beneficial to add in this section the possibility of updating a previous comprehensive geriatric assessment rather than continually undertaking new assessments, if the adult is admitted to hospital fairly regularly (on a planned or unplanned basis). As long as there is always time made for checking the assessment results are up to date, this could be more time-effective for healthcare professionals without undermining the rationale behind this quality statement.

68	Action on Hearing Loss	What the quality statement means for patients, service users and carers	2	We recommend adding *'…, and ensure treatment and care is delivered in the best way possible whilst they are in hospital',* to the end of this paragraph to ensure that people are not kept in hospital any longer than necessary due to their needs not being met. We also think there should be an addition to this paragraph to stress the importance of including an assessment of communication and information support needs. Good communication and accessible information is key for people to be able to express their needs and preferences and for ensuring that the best plans for care in hospital and afterwards are made.
69	Action on Hearing Loss	Definitions of terms used in this quality statement	2	Sensory impairments should be added alongside dementia in the list of multiple impairments. There are over 11 million people across the UK with hearing loss, and over 71.1% of over-70-year-olds have some kind of hearing loss, so it is highly likely that older people with complex needs will have a hearing loss to some degree and will have communication and information needs arising from this. Not meeting hearing needs has serious consequences, including miscommunication, incorrect diagnoses and misunderstanding of preferences, needs and medication, as well as the risk of social isolation and worsened physical and mental health[10].
70	Action on Hearing Loss	Definitions of terms used in this quality statement	2	Learning Disabilities should be added to the list of groups that trigger a comprehensive geriatric assessment. Often learning disabilities can make even routine procedures more complex and communication needs and other preferences will need to be taken into account and this should trigger the need for a comprehensive geriatric assessment to be undertaken, with necessary communication support in place for people to participate in their integrated treatment plan.
71	Action on Hearing Loss	End of section	2	The Equality and Diversity Considerations paragraph on barriers to communication and understanding information, used in the sections about quality statements 3 and 4, should be added to quality statement 2 as well, because good communication and the ability to understand information would be key to ensuring the comprehensive geriatric assessment was a useful process.
72	Alzheimer's Society	Statement 2	2	Proper assessment on arrival in hospital is integral to ensuring care is person-centred. This will help improve outcomes and reduce health inequalities for people with dementia. It is essential that staff have the necessary training in dementia to be able to support people with dementia effectively and to provide appropriate assessments. People are not generally admitted to hospital for their dementia. Some of the most common reasons people with dementia are admitted to hospital are because of falls, broken/fractured hips or hip replacements, urinary tract infections, chest infection or from a stroke.

				Through proper assessment on arrival which takes into account care plans, discussions with family/carers and patient passports such as ‘This is Me’ helps to mediate issues and ensure that care is person-centred and holistic. In line with the Mental Capacity Act people with dementia must be enabled to access an advocate if they no longer have capacity to make decisions. Advocacy services should be publicised in hospitals and to people with dementia so they are aware of the support they can access.
73	Care and Repair England	Statement 2 comprehensive geriatric assessment	2	The expectation of a comprehensive geriatric assessment at the point of admission is welcome in order to help to plan for discharge as early as practically possible. A tool to assess a person’s housing circumstances is available in the Hospital 2 Home pack at http://www.housinglin.org.uk/_library/Resources/Housing/H2H/H2Hchecklist1.pdf
74	College of Occupational Therapists	Older people with complex needs have a comprehensive geriatric assessment started at the point of admission to hospital.	2	Key area for improvement. Housing should be mentioned in the rationale part of this QS. The College of Occupational Therapists’ statement following the ombudsman report backs up the need for good comprehensive assessment of needs and occupational therapists’ essential part in this. https://www.cot.co.uk/news/cot-college/college-warns-unplanned-discharge-will-increase-cycle-readmission
75	Department of Health	Statement 2 (Outcome measure 2A, 2B and 2C)	2	We agree with outcome measures 2a, 2B and 2C because they have clear links to successful discharge. This Quality statement (page 14 of the Draft for consultation): “*Older people with complex needs have a comprehensive geriatric assessment started at the point of admission to hospital*.” and the outcome measure in relation to 2A page 3: “***Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs”*** – are helpful and can be enhanced further if the following involve the support of the voluntary sector where appropriate:

				a) service providers b) the health and social care practitioners, c) the commissioners d) patients, service users, their representatives and carers. The voluntary sector provides valuable support and advice on suitable care arrangements and services, which can contribute positively to the overall comprehensive geriatric assessment.
76	Hospice UK (formerly Help the Hospices)	Statement 2	2	While we understand the case for focusing on older people with complex needs, there should be equal recognition for any person with complex needs who will be at risk of admission to hospital. Many people approaching the end of life, for example, would benefit from a targeted specialist assessment, regardless of their age.
77	NHS England	Statement 2 Process	2	While CGA is a well described and embedded approach among professional geriatricians it is not undertaken routinely in hospitals admitting older people for both medical and surgical reasons. There are significant organisational and workforce implications of ensuring that the CGA is undertaken and utilised in care planning and delivery. There is a currently a significant workforce challenge with geriatrician recruitment at consultant level which could undermine the ability of many provider organisations to deliver this standard, despite the rationale being well evidenced.
78	NHS England	Page 13	2	Need to add in, this should not delay discharge.
79	Nutricia: Advanced Medical Nutrition	Statement 2 (service providers)	2	The draft quality standards do not currently reflect the key areas for quality improvement with adults with social care needs as relevant information about malnutrition for an adult entering hospital should be understood in more detail. Adults should be screened for malnutrition and the risk of malnutrition before they enter hospital. This should be extended into the care standards for the transition between inpatient hospital settings and community or care home settings.
80	Nutricia: Advanced Medical Nutrition	Statement 2 (Commissioners	2	The draft quality standards do not currently reflect the key areas for quality improvement with adults with social care in regards to Commissioners. Commissioners and CCGs should be aware that restricting prescribing to Oral Nutritional Supplements have an impact on the care of geriatric adults when they are admitted. NICE Guidance NG 27 1.3.10 which the guidance takes it source, should also use NICE NG32 1.2.1 to 1.2.6 in its implementation to improve malnutrition care. The restricting and blacklisting of some products places adults at grave risk of malnourishment and therefore increased complications from other illnesses. Quality standards should ensure that Commissioners are aware of restricted prescribing in this area will decrease the desired result.

81	Parkinson's UK		2	Parkinson's UK welcomes the aim of the draft quality statement. However, it is also important that if a person is admitted for a diagnosed condition, such as Parkinson's, the geriatrician should ensure that the individual is reviewed by a relevant specialist wherever possible.
82	Shared Lives Plus	Statement 2	2	This is clearly desirable and should be happening. However, carers need to be aware of this statement so they can ensure such an assessment takes place
83	Skills for Care	title	2	I wonder if it would be better to say 'holistic' assessment either instead of or as well as comprehensive. This ensures a wider assessment as well as a deep assessment. Holistic is a term well known in the sector and would suggest a more thorough assessment taking into account all a person's medical, emotional, physical, social, cognitive, spiritual psychological etc..needs
84	Skills for Care	Rationale	2	I am concerned that assessment in itself does not necessarily lead to an effective longer term plan. (which is the assumption throughout this statement.) The assessment process is separate to the planning process and I think it probably needs to be specified more clearly in the statement itself if that is the expected outcome of the 'comprehensive assessment'
85	Skills for Care	General	2	Skills and knowledge of the people carrying out these 'comprehensive' assessments will need to be evaluated and probably enhanced to ensure this process is satisfactory and achieves the desired outcomes.
86	Skills for Care	Quality measures	2	The measurement will create additional responsibilities for the hospital staff who collect data. Additional support will be needed to measure the quality of the assessment and to establish whether it was indeed 'comprehensive'. It is easy to tick that an assessment has been done but much more difficult to measure the quality of that assessment. Guidance will be required.
87	Skills for Care	Definition of older people with complex needs	2	In list of issues that should trigger an assessment, could you add, 'lack/ absence of significant carer'?
88	Guys & St Thomas NHS Foundation Trust	Question 1	2	Yes very much support this Another outcome could be reduced admissions

89	Guys & St Thomas NHS Foundation Trust	Question 2	2	It is not easily measured and cannot be done by electronic means. It would require spot check audits of patient's notes.
90	Guys & St Thomas NHS Foundation Trust	Question 3	2	Yes, this is business as usual on our Older Persons Unit.
91	Guys & St Thomas NHS Foundation Trust	Question 4	2	Yes
92	Buckinghamshire County Council – Adults and Family Wellbeing	Statement 2	2	Example of local practice: Stoke Mandeville hospital we are piloting a joint assessment at the "front door" of the hospital this assessment follows the patient through the hospital journey with daily updates from all professionals to establish a holistic health and social care need
93	LondonADASS	Quality statement 2	2	We are mainly in agreement with this statement but note the following: The Quality Statement should address the stage before the individual has already been admitted. For significant quality improvement there should be greater focus on avoiding admissions where possible, and consideration for how a complex condition could impact on any admission, particularly if it is intended to be short term. Instead, intermediate care could be considered as an appropriate measure. Therefore the comprehensive assessment should possibly be carried out before the point of admission. Definition of 'complex' needs to be re-defined and not just focused on a particular age group. Those with end of life care needs may have already had a comprehensive assessment that should be recorded on Electronic Palliative Care Co-ordination Systems (EPaCCS). Where does the Continuing Healthcare Assessment (CHC) process fit into this? Is this Geriatric assessment in addition to CHC? The word 'geriatric' is disempowering and is not in line with the Care Act (2014). Clients could just have a full comprehensive assessment. It is not clear who would do this, how it would be resourced or what is meant by 'complex'. Older people with capacity may choose not to participate. Inclusion of a triage system by the hospital palliative care team in A&E would be able to fast track palliative care patients out of A&E as well as the use of the EPaCCS system.

94	LondonADASS	Quality statement 2 (measure)	2	Several issues have been raised in relation to the ease of collecting this data. These include: Collecting data for complex conditions is very challenging, particularly for people with dementia who may struggle to communicate these conditions or who may have dementia without an official diagnosis. Often only one condition or the 'primary condition' will be recorded, meaning the data can be misleading where it is unclear as to the effect other conditions may have had on length of stay. This data will have to be collected by the hospital.
95	London Fire Brigade	General comments on whole draft quality standard	3	We note that the NICE quality standard, Transition between inpatient hospital and community or care home settings, will cover both admissions into, and discharge from, inpatient hospital settings for adults with social care need. We also note that the quality standard is expected to contribute to improvements in a number of outcomes including health-related quality of life and hospital readmissions within 30 days of discharge. The London Fire Brigade (LFB) have a particular interest in the area of people receiving care and support in community or care home settings as our published evidence1 shows that such individuals are significantly at risk from fire. We have worked with Skills for Care, the UK Home Care Association (UKHCA), the Care Quality Commission and the Prime Minister's Dementia Challenge Group to raise awareness of these fire risk factors and the means to reduce them which resulted in knowing how to identify and reduce fire risk for people receiving care and support being a requirement of the Care Certificate for care staff. However, our evidence2 shows that opportunities to identify and reduce the risk of fire are sometimes still missed which has lead to people being readmitted to hospital shortly after being discharged from an inpatient setting, being injured in a way that impacts on their quality of life or, in some cases, has lead to a fatal fire. We therefore ask that assessment of fire risk forms part of the transition planning process for adults with social care needs when discharged from inpatient hospital settings to community or care home settings, as we believe this will contribute to improving the health-related quality of life for people receiving care and support following discharge from inpatient care and reducing the number of hospital readmissions within 30 days of discharge. The underlying principle is that the discharge co-ordinator should contact their local fire service to arrange a home fire risk assessment and for advice on reducing fire risk specific to the person's needs. All UK Fire and Rescue Services provide this assessment free of charge. 1 - Fire Safety of People in receipt of Domiciliary Care – FEP 1952 http://moderngov.london-fire.gov.uk/mgconvert2pdf.aspx?id=920 2 - Review Of Accidental Dwelling Fires and Fatalities – FEP 2484

96	Action on Hearing Loss	Rationale	3	Requiring every adult with social needs to have a discharge coordinator is very important for ensuring a smooth and well planned transition from hospital back into the community. We would suggest adding some wording in this section to make clear the full consequences of not having a discharge coordinator and not planning hospital discharge well: *'…can result in distress and reduced quality of life for people using the service and their carers, and costs for the health and social care system…'*
97	Action on Hearing Loss	Rationale	3	It is likely that adults with social care needs in hospital may not be accessing social care, or may not be aware of what services and support are available. There should be wording added to this paragraph to highlight the importance of signposting to appropriate support outside hospital as part of the discharge coordinators role, and also the importance of recognising unmet social care need when choosing whether or not someone should have a discharge coordinator. It is well known that awareness and take up of social care support is low and hospitals and health settings can be one of the only places that people receive help navigating the system. We recommend the following wording: *'…, and they should be responsible for sharing information on local services and statutory support available. Inpatient hospital settings should also have a good process in place for actively identifying adults with unmet need, who could benefit from having a discharge coordinator and being referred to other health services or to social care services.'*
98	Action on Hearing Loss	What the quality statement means for patients, service users and carers	3	To ensure the discharge planning process is carried out using best practice, we think it would be beneficial to add to the *Adults with social care needs in hospital* section that the plans for discharge will be made involving the adult in question and their families, and also that any preferences and communication needs will be taken into account.
99	Action on Hearing Loss	Definitions of terms used in this quality statement	3	We think the *Discharge coordinator* section should be strengthened by adding some key outputs and considerations required to this paragraph: *'The discharge coordinator must create a discharge plan that's shared with the adult, family members and carers and those involved with ongoing care. They should always seek to involve the person being discharged and take into account the views of their family members and carers, and also take responsibility*

				for having a good knowledge of statutory support and local services and share relevant information as part of transition planning.'
100	Action on Hearing Loss	Equality and diversity considerations	3	The Accessible Information Standard, which becomes mandatory for all NHS and state-funded adult social care providers on 31st July this year, aims to ensure people with disabilities and sensory loss understand information they are given and are able to participate fully in discussions about their care. We therefore think the Accessible Information Standard should be referenced in this equality and diversity considerations paragraph, wherever it is included throughout this quality standard. It would also be beneficial to strengthen the wording of this paragraph to make clear the information needs that need to be taken into account, as well as communication requirements. Suggested wording as follows: Barriers to communication and understanding information can hinder people's understanding of transitions and their involvement in making decisions. For example, learning or cognitive difficulties; physical, sight, speech or hearing difficulties; difficulties with reading, understanding or speaking English. The communication and information needs of people being discharged need to be taken into account and adjustments made to ensure all adults with social care needs can be involved in making decisions about their care. The Accessible Information Standard requires all NHS and adult social care providers to have systems in place to identify, record, flag, share and meet communication needs of people with disabilities and sensory loss, which includes providing accessible information, communication support, and creating an environment where good communication can take place[11].

101	Alzheimer’s Society	Statement 3	3	We believe the Statement should encourage a ‘named’ discharge coordinator. This would help family carers and professional providers involved in the individual’s care and support to engage with that individual and to work together to ensure appropriate measures are put in place. Any support or care services that are required should be arranged before an individual leaves hospital. Any organisations that will be providing these services must be informed of the date and time of the person's discharge, and when they should start to provide the services. A Dementia Support worker provides tailored information, advice and signposting. This role, or similar, could be key in developing discharge coordination. They support people affected by dementia to navigate a complex web of health and social care services to access appropriate information and can help them to plan for the future and self-manage effectively. This array of knowledge and skills makes them perfectly placed to play the role of or support the discharge coordinator. Plans about the date and time of discharge should be discussed with the patient and their carer. Hospital staff must ensure that transport to the person's home or care home has been arranged. They should also take extra care when making plans to discharge someone on a Friday, or during a weekend, as it may be difficult to contact home care workers and GPs on these days. Hospital discharge policies should include details of what to do in such circumstances. Alzheimer’s Society knows that some people with dementia have been discharged during the night. Under no circumstances should this happen and a discharge coordinator should work with hospital staff to ensure the person is discharged at an appropriate time. Badly co-ordinated discharge can lead to a variety of negative outcomes for people with dementia including extended stays in hospital, emergency readmissions and early entry to a care home. In 2011, emergency readmissions within 30 days for people with dementia cost the NHS an estimated £109.6 million, whilst extra days spent in hospital by people with dementia was estimated to have cost the NHS at least £83.3 million. Economic research has found that that £11,296 per person per year could be saved by delaying entry to residential care if just 5 per cent of admissions to residential care were to be delayed for one year as a result of dementia-friendly communities (Alzheimer’s Society, 2013). This would deliver a net saving of £55 million per annum across England, Wales and Northern Ireland.
102	Care and Repair England	Statement 3 discharge coordinator	3	A discharge coordinator is essential to effective discharge so this standard is warmly welcomed. The coordinator should be identified as soon as possible on admission and should consider as part of the discharge plan where a person currently lives and will return to as well as their care and support needs. This will ensure that their home circumstances including the state of repair and suitability of their existing home is addressed before discharge.

103	College of Occupational Therapists	Adults with social care needs in hospital have a discharge coordinator.	3	Key QS. See below for comments on Discharge Coordinator.
104	Department of Health	Statement 3 (Outcome measure 3A to 3D)	3	Quality statement 3 (page 17 *Draft for consultation): "*Adults with social care needs in hospital have a discharge coordinator*", outcome measure 3C (page 3*): "***People know what choices are available to them locally, what they are entitled to, and who to contact when they need help***" and page 18* on what the quality statement means, can be strengthened to include reference to the voluntary sector, where appropriate, in the discharge planning. The voluntary sector can play an important role in explaining some of the care options available to the patient and their representatives upon leaving the hospital. There are a number of recent publications jointly produced by key organisations, including NHS England, Monitor, the LGA, ADASS and Trust Development Authority, which the discharge co-ordinator might find helpful. One example is the *Better Care Fund – signposting resources* (http://www.scie.org.uk/health-social-integrated-care/better-care/delayed-transfers-of-care.pdf?res=true), and another is the "*Delayed transfer of care 'people stranded in the wrong place – behind each number is a personal story*" (http://londonadass.org.uk/wp-content/uploads/2015/11/Lizs-presentation.pdf). It would also be helpful to clarify how outcome measures 3A to 3D will inform this Quality Statement.
105	Healthwatch Bristol		3	This will be welcomed
106	Independent Age	Question 1	3	It would be helpful to include the definition of the discharge co-ordinator more prominently within the document to make their responsibilities more obvious.
107	MHA (Methodist Homes)	Statement 3	3	There is no mention of the discharge coordinator talking with a person's care coordinator; we think this is a crucial link that needs to be included.

108	National Housing Federation	Coordinating Discharge	3	Housing associations could enter into a joint venture with the NHS, making use of an out-of-use hospital ward or nearby NHS-owned site, to build a virtual care ward to which the Trust can quickly move patients with complex needs to recover and get used to any newly diagnosed conditions (such as dementia) before moving home. For some of these customers, home will not be an option, so an attractive offer for an acute trust is a development which provides a mixture of intermediate care and nursing home accommodation. To develop this model, a housing association needs to develop an integrated service, which combines the trust's clinical expertise with the housing association's housing and support expertise.
109	Nutricia: Advanced Medical Nutrition	Statement 3 (Quality Statement for patients & carers)	3	The draft standards do currently reflect the key areas for quality improvement for coordinating discharge. However, adults being discharged should have a discharge coordinator that understands the causes of malnutrition and the management of it. If services are inadequately co-ordinated or there is a breakdown in the continuity of care then people become more vulnerable to the risks of malnutrition. This is especially the case when people are discharged from hospital to their home and the care needed shifts from health to social support. Arrangements should be made to make sure that check on adults prior to and post discharge by a nurse/community nurse that their nutrition is checked and a plan put in place. Information about diet and nutrition should be provided during in-patient stay and/or on discharge. In NICE CG 32 1.5.38 GPs and GP consortia must take an active role in ensuring that people discharged from hospital with nutritional needs are well supported in the community and those at risk of disease-related malnutrition are identified early with the right management pathways being put in place such as www.malnutritionpathway.co.uk because GPs are the first point of contact with the NHS for many patients. We recommend that this is put in place in any future quality standards to ensure that patients are nourished to recover quicker and faster, ensuring less readmissions. In addition the recent Patients Association report on malnutrition which focused on the discharge process and made recommendations for improvement should be taken into consideration…
110	OPAAL UK		3	We are wholly supportive of each person having a named discharge coordinator. We would hope that those in this post have been trained in understanding the benefits of independent advocacy and will make referral to advocacy services as appropriate. OPAAL would like to see this included in the statements.
111	Royal College of Speech and Language Therapists	Statement 3 Coordinating discharge	3	The RCSLT agrees that barriers to communication can hinder people's understanding of transitions and their involvement in making decisions. For example, people with aphasia after a stroke, with communication problems due to dementia or dysarthria due to a neurological condition will need additional time to make decisions and have their needs met. Reasonable adjustments and additional communication support should be provided via a speech and language therapist so people with communication problems can be involved in making decisions about their care.

112	Shared Lives Plus	Statement 3	3	We welcome the statement and the thinking behind it but much will depend on the interpretation in practice. A discharge co-ordinator could be a vital link. Experience shows that when there is one named person facilitating discharge plans it can significantly aid the discharge process. However this could be just a token title if the role is not defined or given the level of importance it requires. For example if the co-coordinator role is an added job to a named nurse they may have to prioritise other nursing tasks given the demands they already have with a very busy workload. A dedicated discharge coordinator would work best to facilitate discharges especially if all the guidance and statements are going to be met. Planning discharge as early as possible, preferably at the time of admission, will enable providers of support to make appropriate plans and, if necessary, source placements.
113	Skills for Care	Statement	3	Can health care afford this level of discharge co-ordinator?
114	Skills for Care	Statement	3	Learning and development programme will be important in establishing the capability of this role.
115	Stroke Association	Statement 3	3	We welcome this recommendation. However we would emphasise that discharge co-ordinators should be sure to share relevant information with social care, so that the appropriate support is in place for a stroke survivor when they arrive at home. We have had some poor reports from stroke survivors of their discharge experience – for example: "My discharge papers had somehow not been completed so nobody knew I was home". "Transfer took from 9:00am to 2:00pm and was a shambles. I missed meals and medication during this period" "I live on my own so there was no-one to care for me, but they sent me home anyway" A dedicated discharge co-ordinator for any patient with social care needs would help to address some of these issues. We would highlight the need for any discharge co-ordinator to be appropriately trained to understand the stroke-specific problems that stroke survivors experience; and their potential inability to communicate these as a result of communication difficulties. Our recent survey of stroke survivors[24] found that 27% of them have either severe or moderate communication difficulties (aphasia), and this percentage is sure to be higher for individuals in the immediate aftermath of their stroke, as aphasia tends to be worst in the first days and weeks following a stroke.

				It is therefore very important that anyone arranging or co-ordinating discharge for stroke survivors understands aphasia, and how to communicate with someone who is suffering from it, in order that they can fully understand their needs and provide for a smooth discharge.
116	Guys & St Thomas NHS Foundation Trust	Question 1	3	Yes
117	Guys & St Thomas NHS Foundation Trust	Question 2	3	Yes although plans are in place to further develop this
118	Guys & St Thomas NHS Foundation Trust	Question 3	3	Yes, we will provide a summary of the Discharge Navigator model that we are implementing
119	Guys & St Thomas NHS Foundation Trust	Question 4	3	Yes at a basic level it could be provided within additional resources i.e. identififying a named member of existing staff as a patients discharge coordinator. However for the role to be properly effective will likely need additional investment. Would expect this to result in bed day savings from reduced LoS (unquantifiable at present) and improved patient experience.
120	Buckinghamshire County Council – Adults and Family Wellbeing	Statement 3	3	Example of local practice: across all local hospitals discharge co-ordinators are in place. Traditional model has been that the joint assessment co-ordinators become involved as the patient nears the end of their hospital journey. However in the light of the pilot this will be reviewed with the co-ordination and the planning for discharge happening much earlier
121	Buckinghamshire County Council – Adults and Family Wellbeing	Statement 3	3	The success of the role of the discharge coordinator in coordinating discharge relies on an effective multidisciplinary approach to ensure coordination and decision making is effective and the appropriate care pathway selected at the right time.

122	LondonADASS	Quality statement 3	3	We strongly support this statement but note the following: The focus should not be on discharge but on coordination in the community which would prevent admission and enable follow up post discharge. Discharge co-ordinators should ensure that checklists for continuing healthcare funding are completed to expedite discharges and ensure patients are not missed who are eligible for CHC
123	LondonADASS	Quality statement 3 (measure)	3	Several issues have been raised in relation to the ease of collecting this data. These include: Data collection - this data will have to be collected by the hospital. Proportionate approach - it is not always necessary for all adults with social care need to have a designated discharge coordinator. Many would be relatively straight forward to discharge. This would address challenges to budgets and time pressures.
124	NHS England	Statement 3 and Statement 4 Rationale	4	These statements are essentially covering the same territory and it is suggested that they can be merged into a single statement. The rationale requires further consideration as it assumes that the information contained in the discharge plan can reduce chance of hospital readmission. While improved communication is likely to achieve this the use of a discharge summary containing a plan may or may not achieve this aim as it is highly dependent on communication. The statement should therefore also give consideration to the methodology and language used to communicate a discharge plan and align this with the contingency plan referred to in statement 1. It would be important to require where possible capture of the preferences of the patient, or the outcome of best interests decision making for future care in this plan. Otherwise the plan may risk not achieving its objectives of improved experience of care. There is also in the rationale an assumption that the person is capable of and achieves understanding of their care and discharge planning. For the likely target population this is highly contingent on the approaches to communication and circumstances of the patient, for example whether they retain mental capacity for present and anticipated future event decision making.
125	NHS England	Statement 3 and Statement 4 Measures	4	In line with the comments above it is suggested that the process measure is not likely to align with a quality measure in terms of what is meaningful to the patient.

126	Action on Hearing Loss	List of quality statements (page 9)	4	This statement should be strengthened throughout the Quality Standard to include the requirement for discharge plans to be shared with family members, carers, providers and professionals involved in ongoing care. This is in line with recommendation 1.5.16 in the corresponding NICE guideline: The discharge coordinator should give the plan to the person and all those involved in their ongoing care and support, including families and carers (if the person agrees). Suggested wording as follows: *‘Adults with social care needs,* ***their family, carers and all those involved in ongoing care,*** *are given a copy of their agreed discharge plan before being discharged from hospital’*
127	Action on Hearing Loss	Quality Statement	4	To ensure join-up between inpatient and community or care home settings, we suggest this quality statement is expanded also to require the discharge plan always to be shared between health care professionals and social care and community based workers involved in a person’s ongoing care. *‘Adults with social care needs,* ***their family, carers and all those involved in ongoing care,*** *are given a copy of their agreed discharge plan before being discharged from hospital’* This is in line with recommendation 1.5.16 in the corresponding NICE guideline: The discharge coordinator should give the plan to the person and all those involved in their ongoing care and support, including families and carers (if the person agrees). The Quality Measure and the descriptions of what the quality statement means for areas of the system would then need adjusting to reflect this broadened requirement too.
128	Action on Hearing Loss	Rationale	4	As in Statement 3, we think it is very important that this section mentions the lack of awareness and referrals to social care and community support and the opportunity offered through implementing this quality statement to proactively signpost and assist people in identifying and addressing support needs. Suggested wording as follows: *‘...Inpatient hospital settings should also have a good process in place for actively identifying adults with unmet need, who could benefit from having a discharge plan and being referred to other health services or to social care services.’*

129	Action on Hearing Loss	What the quality statement means for patients, service users and carers	4	We think there should be more reference in this section to the content of the plan and the process of developing it, to ensure it is as useful as possible. We would recommend a change in wording from *‘should be easy for them to read’* to *‘should be in an accessible format’*, as some people will a format other than plain English or considerations in text formatting. We suggest adding the need for the plan to be shared with families and carers (if the person agrees), in line with the corresponding NICE guideline to these Quality Standards (recommendation 1.5.16). We also suggest an addition to the text outlining some of the contents of the plan, particularly the need for it to: be co-developed with the person receiving care (recommendation 1.5.14 in corresponding NICE guidance) in line with people’s preferences; outline arrangements with all areas of ongoing care; and signpost to services and support available that people can benefit from.
130	Action on Hearing Loss	Definitions of terms used in this quality statement	4	We think the inclusion of ‘details of other useful community and voluntary services’ is very important in this list of things to include in the discharge plan, and that the importance of signposting to local services and support should be mentioned as much as possible throughout the document to improve signposting and referral practices. We also feel that it will be important to include *‘details of communication and information preferences’* on this plan, and this should be added to the list of bullet points. Good communication and appropriate information provision will be essential for ensuring people understand what is happening to them and are able to be express their needs and preferences at all points during transition into ongoing care.
131	Action on Hearing Loss	Equality and diversity considerations	4	We recommend text being added to this section to ensure that people understand the information in their plan. The requirements of the Accessible Information Standard also need to be added. We recommend the following wording: ‘Barriers to communication and understanding information can hinder people’s understanding of transitions and their involvement in making decisions. For example, learning or cognitive difficulties; physical, sight, speech or hearing difficulties; difficulties with reading, understanding or speaking English. Communication needs should be taken into account and adjustments made to ensure all adults with social care needs can be involved in making decisions about their care. Information should be provided in an accessible format, particularly for people with physical, sensory or learning disabilities and those who do not speak or read English, and the person providing the information should check that it has been understood. The Accessible Information Standard requires all NHS and adult social care providers to have systems in place to identify, record, flag, share and meet communication needs of people with disabilities and sensory

				loss, which includes providing communication support, accessible information and creating an environment where good communication can take place[12].
132	Alzheimer’s Society	Statement 4	4	It is important that the Discharge Plan includes an assessment of the person's needs and living environment, with consideration given to the people involved in supporting them - often referred to as their 'support network'. There must also be confirmation that any required services are in place in time for the discharge - for example, home visits needed to help with personal care, or grab rails in the home to help with support and stability. The hospital discharge assessment should take into account whether the person with dementia will benefit from intermediate care. The discharge plan, with permission, should be shared with the family and care providers that are integral to the continued care and support of the individual. This will allow support networks to make sure preparations are carried out before the individual is discharged.
133	Care and Repair England	Statement 4 discharge plan	4	The discharge plan should also include information on and plans to address, where appropriate, people’s housing circumstances and needs. We are aware of work being developed on ‘care passports’ for frail older people in hospital which aim to facilitate better hospital discharge by knowing the person. In developing support tools for improving quality in discharge planning we would urge NICE to work with NHS England and others locally to improve information and communication both to the patient during their time in hospital and about the patient for those supporting them in hospital and in preparation for returning to the community.
134	College of Occupational Therapists	Adults with social care needs are given a copy of their agreed discharge plan	4	Essential for person centred care. Involvement and buy in from others is key.

		before being discharged from hospital.		
135	Department of Health	Statement 4 (Quality Statement and Outcome measures 4A and 4B)	4	We fully support and agree with this Quality statement (page 20): "*Adults with social care needs are given a copy of their agreed discharge plan before being discharged from hospital*" and its rationale (page 20 in the Draft for consultation document). However, the word **safely** before "discharged" should be added to the Quality Statement and to the section on page 21 "*What the quality means* …". For example, the Quality statement will read as: "*Adults with social care needs are given a copy of their agreed discharge plan before being* **safely** *discharged from hospital*." On page 21 – the sentence relating to health and social care practitioners will read: " … *ensure that they involve the discharge coordinator in all decisions about* **safe** *discharge planning for adults with social care needs.* " Similarly, on the same page (21) under Adults with social care needs in hospital, the sentence will read as: " ... *should be given the name of the person who will be responsible for coordinating their* **safe** *discharge from hospital*." This should put the patient's wellbeing at the forefront of the discharge process and may give reassurance to both the individual and their representatives. Also, it would be helpful to clarify how outcome measures 4A and 4B will inform this Quality Statement.
136	Headway – the brain injury association	Statement 4 (process)	4	We should suggest explicitly stating that the copy of the discharge plan should be a written plan.
137	Healthwatch Bristol		4	It is not just about getting a copy of the discharge plan, but also making sure they understand what is written and that there is a contact number and name should anything go wrong
138	MHA (Methodist Homes)	Statement 4	4	There is no mention that care home providers should have a copy of the agreed discharge plan.

139	National Housing Federation	Planning discharge	4	Hospital discharge support has focused on ensuring the home is ready for the patient to return home, and that the support is there for them to get back to living independently as quickly as possible. One of the major challenges is information sharing between the NHS and housing associations so patient information can used to used plan effective hospital discharge by ensuring the right support package and assessment of housing need can taken in to consideration.
140	Nutricia: Advanced Medical Nutrition	Statement 4 (Rationale)	4	The rationale for this quality statement should also include a rationale that highlights that dietitians and other health care professionals need to be aware of malnutrition as part of a coordinated discharge. NICE GC 32 1.5.2 recommends that people having nutrition support in hospital should be monitored by healthcare professionals with the relevant skills and training in nutritional monitoring. This should be increased across the board. NICE CG 32 recommendation 1.1.7, states that all hospital trusts should have a nutrition steering committee working within the clinical governance framework. Malnutrition should be included in a discharge plan coordination.
141	Nutricia: Advanced Medical Nutrition	Statement 4 (service providers)	4	NICE CG 32 1.3.5 recommends that healthcare professionals should ensure that people having nutrition support, and their carers, are kept fully informed about their treatment. They should also have access to appropriate information and be given the opportunity to discuss diagnosis and treatment options. This is in vein with NICE CG 27 1.6.3 and 1.5.16. We also recommend that out of hours care providers the service provides ensure that patients and carers are able and confident enough to be nutritionally independent at home. This can be through training and leaflet information. NICE CG 32 recommends a Healthcare Professionals should ensure that patients having enteral or parenteral nutrition in the community, should be empowered to have access to appropriate of information in formats, languages and ways that are suited to an individual's requirements. This includes their carers also. Consideration should be given to cognition, gender, physical needs, culture and stage of life of the individual.
142	OPAAL UK		4	The discharge plan needs the full understanding and agreement of the person being discharged but we do not feel that the standard is specific enough about how this should be achieved. OPAAL's concern is that an older person with social care needs may struggle to be fully involved in this process without the support of an independent advocate
143	Royal College of Speech and Language Therapists	Statement 4 Discharge plans	4	For all people with communication problems it is essential that their discharge plans is provided in an accessible format and in a format suitable for their needs. Additional time should be spent with people with communication problems to explain their plan to ensure that they understand the content of this. It cannot be assumed that merely giving someone their plan equates to understanding.
144	Shared Lives Plus	Statement 4	4	We assume that the discharge plan will be supplementary to the care/support plans that would detail the support an individual needs when leaving hospital. External agencies that may be involved in giving short term support upon discharge need all available information as soon as discharge occurs, so it will be important to give this the priority in needs to be effective.

145	Skills for Care	Rationale	4	Concern about discharge plan being given to adults so they can pass it on to whoever. How do we deal with adults who lack capacity and understanding? Does it need to specify carers, advocates, relatives, significant others as identified / named by the adult? Whose responsibility is it to share this plan? Who does the plan belong to? Does the person have to give consent to the plan being shared?
146	Skills for Care	Rationale	4	Not all adults will be able to understand their plan no matter how simple the plan is formulated. This links in with comment above about capacity and what can be done where there is little or no capacity This will create difficulty in ensuring ‘person agrees and understands their own discharge plan prior to discharge’.
147	Skills for Care	Rationale	4	Is the plan shared with the community pharmacist?! Is some guidance needed about who the plan might be shared with in practice? This would be helpful for adults with social care needs, carers, relatives and significant others. Could this be a recommendation for trusts etc. in implementation?
148	Stroke Association	Statement 4	4	We welcome this quality standard and we are glad to see that it has been identified as an area that needs to be improved. Our recent survey of stroke survivors found that almost 40% of stroke survivors did not have a care plan in place when they went home from hospital. 30% of stroke survivors did not feel prepared when it was time to return home. We would stress the need for joined up working between health and social care when preparing for the discharge of a stroke survivor. According to the latest Sentinel Stroke National Audit Programme (SSNAP) data, 11% of stroke survivors do not receive a joint health and social care plan on discharge.[25] Given that 48% of stroke survivors and their carers report problems caused by either poor or non-existent co-working between health and social care, this is clearly an area where improvements need to be made.[26] We emphasise again that many stroke survivors experience communication difficulties such as aphasia, and may have difficulty understanding a discharge plan. As outlined above, our survey reports that far fewer people had a care plan in place that the SSNAP statistics show – so it suggests that plans may not be adequately explained or communicated to stroke survivors and improvement in this area is needed. It is very important that the relevant professionals ensure that the stroke survivor understands what is being communicated to them.

149	Guys & St Thomas NHS Foundation Trust	Question 1	4	Yes
150	Guys & St Thomas NHS Foundation Trust	Question 2	4	No but it could be manually collected and audited on adhoc basis.
151	Guys & St Thomas NHS Foundation Trust	Question 3	4	No
152	Guys & St Thomas NHS Foundation Trust	Question 4	4	Yes as it is common practice already. Auditing that it does occur would however be an additional task.
153	Royal College of General Practitioners	Statement 4	4	This should be readily measured through the National Inpatient Survey, a copy of a discharge summary is not enough evidence of improved quality of care on its own. It tells us nothing of the quality, accuracy and completeness of the summary, which may be necessary for subsequent care decisions made by GPs and other clinicians in the primary care setting. If also does not say whether the patient/carer/family was involved in the development of the summary, and whether these parties agree to or indeed understand the summary provided. Although there are other questions in the NIS about patient-involvement in the discharge process, it is not possible to extrapolate this to the discharge summary itself; it is therefore not clear how the additional information about discharge summary quality/content could be readily measured using currently available routine data. (RP)
154	Buckinghamshire County Council – Adults and Family Wellbeing	Statement 4	4	We welcome this approach reflects how we operate at the present time in hospitals across Buckinghamshire

155	LondonADASS	Quality statement 4	4	We strongly support this statement but note the following: It is important that the Discharge Plan includes an assessment of the person's needs and living environment, with consideration given to the people involved in supporting them - often referred to as their 'support network'. There must also be confirmation that any required services are in place in time for the discharge - for example, home visits needed to help with personal care, or grab rails in the home to help with support and stability.
156	LondonADASS	Quality statement 4 (measure)	4	We support this measure but note that this data will have to be collected by the hospital.
157	Action on Hearing Loss	What the quality statement means for health and social care practitioners	5	To ensure that carers and family members have the information and support they need, we suggest adding to this paragraph the following: *'Health and social care practitioners should ensure family members and carers have information on local services and support that could benefit the person they are looking after, and where to get support for themselves.'*
158	Action on Hearing Loss	What the quality statement means for patients, service users and carers	5	As this section is about involving carers and family members, there should be a separate section here on what this quality statement means for carers.
159	Alzheimer's Society	Statement 5	5	Family carers are often excluded from planning and decision making, particularly in relation to hospital discharge. When informal care provision breaks down, people with health and social care needs may need to be admitted to hospital. They are also more likely to experience delays in discharge from hospital and in many cases (particularly in relation to individuals with dementia), they are discharged straight from hospital to a care home (Alzheimer's Society, 2009; CSCI 2004, 2005 cited in the National Dementia Strategy – Equalities Action Plan).

160	College of Occupational Therapists	Adults with social care needs who will be supported by family and carers after discharge from hospital have them involved in discharge planning.	5	Essential again. Carers are often key people to ensure success of effective discharge and prevention of readmission. Is it worth putting in here about ensuring patients agree, in line with ***1.5.30 With the person's agreement, include the family's and carer's views and wishes in discharge planning.***
161	Department of Health	Statement 5 (Quality Statement)	5	- This statement: "*Adults with social care needs who will be supported by family and carers after discharge from hospital have them involved in discharge planning*" – can be supported further by recommending to the service providers, the health and social care practitioners, the commissioners and patients, services and carers that the voluntary sector be involved in the planning too. Patients and their representatives will be able to have access to vital guidance and information on choice of available and appropriate care services (e.g. domiciliary care or suitable care home placements) if the voluntary sector are allowed to be involved in the discharge planning. This helps to have: The opportunity to access support and information to help them manage their care needs People know what choices are available to them locally, what they are entitled to, and who to contact when they need help People are supported to plan ahead and have the freedom to manage risks the way that they wish.
162	Hospice UK (formerly Help the Hospices)	Statement 5 (Rationale)	5	It would be helpful to distinguish between paid and unpaid carers in this statement.

163	Independent Age	Statement 5 – Statement	5	This statement should not only be relevant for family and carers who will offer support to the person being discharged from hospital but all relevant family members and carers. The consideration of all carers and family members should reflect the 'willing and able' principle included in the Care Act 2014, which states that an assessment must consider care and support needs separate from any support being provided by a family member or carer. A family member or carer cannot be assumed to be providing support, unless they are willing and able
164	Independent Age	Statement 5 – Structure	5	There should be an obligation for all relevant carers and family members to be provided with information on hospital discharge and where to get support in the future. This should cover information about their diagnoses and treatment and a complete list of their medicines when they transfer between hospital and home as stated in the NICE guideline. Information should also be available about who to contact in case of emergency or assistance with equipment. This would follow similar suggestions made for the discharge coordinator in the NICE guidelines. Information should be given to carers at least 24 hours ahead of discharge in order that they have time to read the material and ask any questions they might have.
165	Shared Lives Plus	Statement 5	5	Carers and the person themselves should be involved in all stages of a persons stay in hospital and most importantly at discharge. However to make this statement work it needs to be a meaningful involvement based on conversations not on assumptions. Guidance may be needed to help staff understand the range of people who may be involved as carers.
166	Skills for Care	Statement / rationale	5	Family members, carers and significant others need to be identified and agreed by adult with social care needs and permission / consent to share given by them. Again guidance might be helpful on this issue.
167	Stroke Association	Statement 5	5	We welcome this quality standard and the recognition that families and carers are extremely important for ensuring a smooth transition from hospital to home. According to our State of the Nation report, 1 in 5 stroke survivors in the UK are dependent on family and friends.[27] 41% of stroke survivors need help with activities of daily living when they are discharged, and they are often dependent upon their carers in this regard.[28] Currently, many families and carers do not feel prepared when a stroke survivor is discharged. According to our recent survey of stroke survivors, almost 40% did not feel that their carer had enough support when they returned home. 53% of carers either disagreed or strongly disagreed with the statement, "I felt prepared when the person I care for was discharged from hospital". This is an area where improvement is clearly needed and improving family and carers in discharge planning can help to make the transition from hospital to home smoother.
168	Stroke Association	Statement 5	5	We would also emphasise the importance of providing support for those stroke survivors who do not have family or friends on hand to provide care when they are discharged. According to latest SSNAP data, 26% of patients who are discharged home following a stroke are living alone.[29] These people are particularly

				vulnerable, and it is important that their discharge is planned in such a way that adequate support will definitely be available for them in the absence of family or friends close by.
169	Guys & St Thomas NHS Foundation Trust	Question 1	5	Yes
170	Guys & St Thomas NHS Foundation Trust	Question 2	5	Do not currently collect this data systematically and would be difficult to capture – would likely need to be monitored via local audit rather than systematic recording.
171	Guys & St Thomas NHS Foundation Trust	Question 3	5	No
172	Guys & St Thomas NHS Foundation Trust	Question 4	5	Yes achievable – we currently involve family and carers in discharge planning. Data capture and recording of this could become onerous though so if required would result in additional capacity constraints.
173	Buckinghamshire County Council – Adults and Family Wellbeing	Statement 5	5	We welcome this approach reflects how we operate at the present time in hospitals across Buckinghamshire
174	LondonADASS	Quality statement 5	5	We are mainly in agreement with this statement but note the following: Professional care providers play a vital role in helping someone with social care needs resettle after a period in hospital. Too often they are not involved in relevant conversations around discharge, meaning services are not in place when they are needed. Often these providers are well placed to know the preferences of the individual, particularly if the individual is living with dementia and may struggle to communicate or lacks capacity.

175	LondonADASS	Quality statement 5 (measure)	5	We support this measure.
176	Action on Hearing Loss	Rationale	6	It is very important that people are able to understand their medication and how to take it - the importance of the list of medicines being in an accessible format and understood is crucial and we therefore suggest it is added to the wording in this paragraph, for example as follows: 'Giving people a complete list of their medicines on discharge, in an accessible format that they understand, helps them…' We know that for people with all levels of hearing loss, for example, understanding medication and diagnoses can be problem, and the unnecessary prescriptions and appointments arising from this are problematic for the person with hearing loss and are costly for the health system. Action on Hearing Loss research showed that more than a quarter of people with hearing loss have had difficulties understanding their diagnosis in a GP appointment (28%) and one in five (19%) have been unsure about their medication[13].
177	Action on Hearing Loss	What the quality statement means for service providers, health and social care practitioners, and commissioners	6	To ensure that due importance is placed on people understanding their medicines, we think it should be stated here that the list of medicines should be '*in an accessible format for the person being cared for and those involved in their ongoing care'*, and this should be added to the end of the relevant sentence for service providers, health and social care practitioners, commissioners and adults with social care needs.
178	Action on Hearing Loss	Equality and diversity considerations	6	We think the list of accessible formats is a good inclusion for this quality statement, but think some changes should be made to ensure that the accessibility of the document for both the adult with social care needs and any family members/ professionals involved in ongoing care is considered, and also to make it clearer that implementation of the Accessible Information Standard is mandatory for all NHS and state-funded adult social care providers (from 31st July 2016). We suggest wording such as the following to reflect these points:

				'Information should be provided in a range of formats that suit the information needs of both the adult with social care and anyone else involved in their ongoing care..or translated material. As of 31st July 2016 all NHS and adult social care providers must implement the requirements of the Accessible Information Standard, which includes the need to identify, record, flag, share and meet communication and information needs of people with disabilities and sensory loss[14].
179	College of Occupational Therapists	Adults with social care needs are given a complete list of their medicines when they are discharged from hospital.	6	There seems to be a requirement in the discharge plan already – statement 4. If there is going to be a separate standard for medications it should not just be about a list. Information and advice should also be offered to the person if there have been any changes whilst as an inpatient and what this might mean. Also, what follow up with regard to this is needed. i.e. GP review. If a person is having a restarted Care package and there is a change of medication what about the instructions given them on discharge.
180	Headway – the brain injury association	Statement 6 (What the quality statement means for patients, service users and carers)	6	We should suggest that the list of medications should be provided to carers and family members of the adult with social care needs if the adult presents difficulties with cognitive processing that could hinder their ability to take medications themselves, such as memory problems.
181	Healthwatch Bristol		6	Having a list of medications and what they are for
182	Hospice UK (formerly Help the Hospices)	Statement 6 (rationale)	6	It would be helpful if the statement also made reference to the importance of the person understanding any medication changes to help ensure compliance. This would promote conversations with people about their medication.

183	MHA (Methodist Homes)	Statement 6	6	Information about medicines, should be retained as an individual separate quality statement. If it were to be merged into Statement 4 Discharge Plans, it might lose its impact and might be missed.
184	OPAAL UK		6	Statement 6 talks about a list of medications but OPAAL feels that such a list is insufficient. There also needs to be an explanation and check on understanding of the person being discharged. It would also be helpful to follow this understanding up at some early point once the person being discharged has returned to the community. This would help prevent non-compliance and support safe use of medications.
185	Parkinson's UK		6	As above, we welcome the statement that *'adults with social care needs are given a complete list of their medicines when they are discharged from hospital'*. However, it is vital that this goes further, to clarify to social care professionals whether a person with is able to self-administer their medicines, and when medications must be administered – in cases where this is time critical, like for people with Parkinson's. A carer of a person with Parkinson's explains: '*When my mum ran out of Amantadine and had to go cold turkey, her condition deteriorated dramatically. She struggles to open and close doors, needs help with household jobs and sometimes can't even leave the house. I'm worried she might fall, which could be disastrous."*
186	Royal College of Speech and Language Therapists	Statement 6 Medicine management	6	The RCSLT has evidence of harm and even death that can result when people with dysphagia are given the wrong medication or access and consume thickening products incorrectly (Patient Safety Alert NHS/PSA/W/2015/002). It is essential that thickening powder used as part of the treatment of people with dysphagia (swallowing problems) are properly stored and managed. Data should be collected on compliance with medicine management.
187	Shared Lives Plus	Statement 6	6	Clearly necessary but we would assume this would be included in the discharge plan.
188	Skills for Care	Statement	6	Not sure this statement adds anything as I agree medication is covered in previous statement.
189	Guys & St Thomas NHS Foundation Trust	Question 1	6	Yes
190	Guys & St Thomas NHS Foundation Trust	Question 2	6	No but it could be done

191	Guys & St Thomas NHS Foundation Trust	Question 4	6	Yes as it is common practice already. Auditing that it does occur would however be an additional task.
192	Royal College of General Practitioners	Statement 6	6	The complete list of medication on discharge needs to be provided by the hospital and not the GP. Information is frequently not transmitted to the GP until some time after discharge (even up to 4 weeks) and the individual may be admitted to a hospital distant from their home. In order to achieve the desired safety outcomes, clear information needs to be given to the patient on hospital discharge. As mentioned previously in statement 4, additional information, beyond simply provision of a summary, is required, such as the actual content of the summary. Although a list of medicines would be of value, the nature of that list is crucial. In particular, it needs to be clear from the list what changes have been made to ensure these are properly implemented at the point of medicines reconciliation; in addition, is the rationale for the new medication regimen made clear (e.g. why was a specific drug stopped or dose changed). However, this additional information about medicines would require specific new data collection.
193	Buckinghamshire County Council – Adults and Family Wellbeing	Statement 6	6	We welcome this approach reflects how we operate at the present time in hospitals across Buckinghamshire
194	LondonADASS	Quality statement 6	6	We are mainly in agreement with this statement but note the following: We agree with inclusion of a list of medication, however for people living with dementia and other complex issues there should be alternative methods of delivering information, and it should not be assumed that this list will provide what is required. Many people will need further explanation of what the list means and many people will receive care and support services that will also need access to the list. It is important to explain how the list might change over time, as needs change. Everybody should be given a complete listing of their medicines, not just those known to social care. It is necessary to include adults who are self-funding their care or who are only known to health professionals.
195	LondonADASS	Quality statement 6 (measure)	6	We support this measure but note that this data will have to be collected by the hospital.

196	Healthwatch Essex	Q.5	Question 5	Yes it is covered by statement 4 on discharge plans, but the hospital staff need to clearly explain the following both to the patients and their family members or carers: 1) if and why the patients are not receiving the medication that they were receiving before hospitalization, 2) if they have been prescribed new medication, why they have been prescribed these medication and any side-effects they may experience, and 3) if and when they should start taking their old medication again.
197	Guys & St Thomas NHS Foundation Trust	Question 5	Question 5	Helpful to have medicines as a separate quality statement like this as although is part of 4 it could be missed.
198	Royal College of General Practitioners	Question 5	Question 5	Medicines information is not covered by statement 4 on discharge plans. The range of medication errors on discharge is so great that this needs a separate information standard delivered with discharge medication.
199	Independent Age	Question 5	Question 5	We believe that medicines information is adequately covered by statement 4.
200	OPAAL UK	Question 5	Question 5	As medication is covered in the discharge plan there seems little need for a separate statement. Our concerns about a medications “list” is noted above at comment 3. Is the fact there is a separate statement about medications indicate concern about the viability/use of discharge plans? If not then Statement 4 covers with this issue and makes Statement 6 superfluous.
201	Healthwatch Essex	Q1	Additional area	Based on the findings of our research on hospital discharge planning processes we contend that the draft does not include a key area for quality improvement regarding the transitions between inpatient hospital settings and community or care home settings for adults with social care. Patients and their carers experience difficulties with the co-ordination of care post-discharge. For example, in our study many patients reported that they had been discharged without having a clear understanding about their follow-up care such as outpatient appointments times, scans and other tests. Although on the day of their discharge they were told that either hospital or primary care staff would contact them to book an appointment or have a telephone consultation within a short period of time, these rarely occurred on time. Many participants reported that they had waited for weeks until a healthcare professional had contacted them or that they had to call the hospital in order to arrange an appointment. As a result many participants reported that they felt unsure and anxious after they had been discharged because they were unclear about who was in charge of organising their care post-discharge. We suggest that the quality standard needs to include a statement on the co-ordination of care post-discharge.

202	Independent Age	Question 1	Additional area	We believe that the recommendation in the NICE guideline that 'a GP or community-based nurse should phone or visit people at risk of readmission 24-72 hours after discharge' should be included as a quality standard.
203	Independent Age	Question 1	Additional area	We believe that a key area for quality improvement concerns the quality of information and advice provided to people choosing a care home to move to from an inpatient hospital setting. Adults with social care needs in hospital who are moving to a care home should be supported with information and advice with which to choose which care home to move to. This would build on the point made in the guidelines to 'ensure that people do not have to make decisions about long-term residential or nursing care while they are in crisis'. NICE should consider including information and advice provision as an additional quality standard, or including it in Statement 5 for supporting family and carers in discharge planning.
204	Parkinson's UK		Additional area	We are disappointed that the draft quality standard makes no mention of, nor recommend having timely assessments for NHS Continuing Healthcare as part of discharge arrangements, which could enable smoother transitions between hospital and community social care for people with complex needs, such as those with advanced Parkinson's. The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care explicitly states: "*Arrangements for applying the Framework should form an integral part of local hospital discharge policies, and should be implemented in such a way that delays are minimised. Timely assessments will prevent whole system delays within the acute hospital sector. LAs, CCGs and other NHS bodies providing hospital services should ensure that there is clarity in local discharge protocols and pathways about how NHS continuing healthcare fits into these processes, and what their respective responsibilities are."* The Framework suggests measures which will minimise potential delays which can occur during the transition process between inpatient hospital settings and community or care home settings as a result of NHS Continuing Healthcare assessments. We believe these must also be given due regard in this NICE Guideline. A report* produced by the All-Party Parliamentary Group on Parkinson's found that the process of applying for NHS Continuing Healthcare is both extremely complex and time consuming. The challenges throughout the lenghty process can lead to delays in hospital discharge, or people having to pay for the costs of care in while they await the results of their assessment. It is clear that agreeing funding arrangements for care when people are discharged is slowing down the system, resulting in delayed discharge. Age UK found that since June 2010 the NHS has lost almost two million bed days** owing to patients waiting for social care assessments, a care home place, a care home package, or adaptations to be made to their own homes. They estimated this cost the health service £526 million during this period. Additionally King's Fund research released in January 2014 showed that 3,000

				beds a day*** were occupied by people who were fit to leave but stuck in hospital while funding or assessment was resolved. **Recommendation:** The process of Continuing Healthcare assessments must always be considered and should begin as soon as possible following admission, to avoid unnecessary delays in hospital discharge, particularly if a person does not have a social care package arranged prior to their admission. This must be led by the health professional responsible for coordinating discharge. *Failing To Care: The All Party Parliamentary Group report on NHS continuing care: http://www.parkinsons.org.uk/sites/default/files/failingtocare_appgfullreport.pdf ** Age UK, Nearly 2m NHS days lost from delayed discharge: http://www.ageuk.org.uk/latest-news/nearly-2m-nhs-days-lost-delayed-discharge/. ***King's Fund, A new settlement for health and social care (2014)
205	Stroke Association	General	Additional area	We would like to see a quality standard that specifically relates to appropriate timing of discharge, and specifically to Early Supported Discharge as this is a key area where improvement is needed. Early Supported Discharge can improve outcomes for patients, including reducing long-term mortality, institutionalisation, and increasing independence.[17] Therefore it would be appropriate to use the availability of Early Supported Discharge as a measure of quality. The new NICE quality standard on stroke care stipulates that adults who have had a stroke should be offered early supported discharge it is suitable for them.[18] Currently only 40% of Early Supported Discharge teams are providing a service on 5 days a week or more – only 29% are delivering a 7 day service.[19] This is an area where there is a clear need to drive up quality. We note that it was identified by stakeholders in the briefing paper as an area where quality improvement was needed. Therefore we would like some clarity from the panel on why it was not selected as an area on which to develop a quality standard.
206	Stroke Association	General	Additional area	We would also like to see a quality standard on access to community services, as we have heard from clinical colleagues that poor access to community services can be a barrier to discharge for stroke patients. In general, we would highlight the need for appropriate stroke rehabilitation services to be available to all those who require them once they have been discharged from hospital, whether that is into a care home or into the community. For example, access to psychological support is currently poor, with a median waiting time of over 10 weeks.[20] Stroke survivors should not have to wait for such a long time following discharge for the psychological support they require.

207	Stroke Association	General	Additional area	We would also welcome a quality standard focused on follow up after discharge. In a recent survey we conducted, 47% of stroke survivors reported that they were not contacted by a healthcare professional after they returned home from hospital, which is unacceptable. Lack of contact may lead to unplanned and unnecessary hospital admission. SSNAP figures indicate that, nationally, only 26% of eligible stroke survivors are receiving a six month assessment.[21] In London, only 16% of patients are receiving six month assessments.[22] Although they are mandatory, 6 month reviews are not being commissioned at all in nearly half of areas.[23] There is a clear need to encourage Clinical Commissioning Groups to commission appropriately in order to prevent unnecessary re-admissions.
208	Pfizer	Thank you for the opportunity to participate in the consultation for this topic. I can confirm that Pfizer have no further comments to submit.		

[1], [2] Action on Hearing Loss (2015) Hearing Matters. Available at: www.actiononhearingloss.org.uk/hearingmatters
[3],[4] Davis et al (2007) Acceptability, benefit and costs of early screening for hearing disability: A study of potential screening tests and models. Health Technology Assessment 11: 1–294
[5] NICE (2013) Mental wellbeing of older people in care homes. QS50
[7] Ringham (2013) Access all areas: A report into the experiences of people with hearing loss when accessing healthcare. Action on Hearing Loss (available at http://www.actiononhearingloss.org.uk/accessallareas.aspx)
[8] Calton (2012) Life Support; the provision of social care for people with hearing loss. Available at: www.actiononhearingloss.org.uk/lifesupport
[9] Our Health in Your Hands, 2012. Survey of BSL users about access to communication support in healthcare. Available at: http://www.actiononhearingloss.org.uk/get-involved/campaign/equal-treatment/the-problem/survey-of-bsl-users.aspx Accessed 25 June 2015.
[10] Action on Hearing Loss (2015) Hearing Matters. Available at www.actiononhearingloss.org.uk/hearingmatters
[11] Accessible Information Standard: https://www.england.nhs.uk/wp-content/uploads/2015/07/access-info-spec-fin.pdf
[12] Accessible Information Standard: https://www.england.nhs.uk/wp-content/uploads/2015/07/access-info-spec-fin.pdf
[13] Ringham (2013) Access all areas: A report into the experiences of people with hearing loss when accessing healthcare. Action on Hearing Loss (available at http://www.actiononhearingloss.org.uk/accessallareas.aspx)
[14] Accessible Information Standard: https://www.england.nhs.uk/wp-content/uploads/2015/07/access-info-spec-fin.pdf
[15] http://www.ombudsman.org.uk/reports-and-consultations/reports/health/a-report-of-investigations-into-unsafe-discharge-from-hospital
[16] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf
[17] Langhorne P, et al., 2005, ‘Early supported discharge services for stroke patients: a meta-analysis of individual patients’ data’, Lancet 365, 501–6
[18] National Institute for Care Excellence (NICE), ‘Quality Standard – Stroke in Adults’ (updated April 2016), https://www.nice.org.uk/guidance/qs2/chapter/Quality-statement-4-Early-supported-discharge
[19] Royal College of Physicians, ‘Sentinel Stroke National Audit Programme (SSNAP) Post-Acute Organisational Report, Phase 2’, December 2015 https://www.strokeaudit.org/Documents/Results/National/2015/2015-PAOrgPublicReportPhase2.aspx
[20] Royal College of Physicians, ‘Sentinel Stroke National Audit Programme (SSNAP) Post-Acute Organisational Report, Phase 2’, December 2015 https://www.strokeaudit.org/Documents/Results/National/2015/2015-PAOrgPublicReportPhase2.aspx
[21] Royal College of Physicians, ‘SSNAP Clinical Audit October-December 2015 Public Report’, March 2016, https://www.strokeaudit.org/Documents/Results/National/OctDec2015/OctDec2015-PublicReport.aspx
[22] London Stroke Strategic Clinical Leadership Group, ‘Six Month Stroke Reviews: A Commissioning Guide’, August 2015, http://www.londonscn.nhs.uk/wp-content/uploads/2015/11/stroke-six-mo-review-commissioning-guide-082015.pdf

[23] Royal College of Physicians, ‘SSNAP National Audit Programme Post-Acute Organisational Audit Report, Phase1’, June 2015, https://www.strokeaudit.org/Documents/Results/National/2015/2015-PAOrgPublicReport.aspx
[24]A New Era for Stroke, conducted by The Stroke Association in March 2016. 1,174 stroke survivors in England, Scotland, Wales and Northern Ireland responded to the survey.
[25] Royal College of Physicians, ‘SSNAP Clinical Audit October-December 2015 Public Report’, March 2016, https://www.strokeaudit.org/Documents/Results/National/OctDec2015/OctDec2015-PublicReport.aspx
[26], [27] Stroke Association, ‘State of the Nation’, January 2016, https://www.stroke.org.uk/resources/state-nation-stroke-statistics
[28] Stroke Association, ‘State of the Nation’, January 2016, https://www.stroke.org.uk/sites/default/files/state_of_the_nation_2016_110116_0.pdf
[29] Royal College of Physicians, ‘SSNAP Clinical Audit October-December 2015 Public Report’, March 2016, https://www.strokeaudit.org/Documents/Results/National/OctDec2015/OctDec2015-PublicReport.aspx
[30] https://www.rcplondon.ac.uk/file/382/download?token=A6yyzBjB

Registered stakeholders who submitted comments at consultation

- Action on Hearing Loss
- Alzheimer’s Society
- Buckinghamshire County Council –Adults and Family Wellbeing
- Care and Repair England
- College of Occupational Therapists
- Department of Health
- East Midlands Academic Health Science Network on behalf of the Patient Safety Collaborative Discharge cluster
- Guys & St Thomas NHS Foundation Trust
- Headway – the brain injury association
- Healthwatch Bristol
- Healthwatch Essex
- Hospice UK (formerly Help the Hospices)
- Independent Age
- London Fire Brigade

- London ADASS
- MHA (Methodist Homes)
- National Housing Federation
- NHS England
- Nutricia: Advanced Medical Nutrition
- OPAAL UK
- Parkinson’s UK
- Pfizer
- Royal College of General Practitioners
- Royal College of Physicians
- Royal College of Speech and Language Therapists
- Shared Lives Plus
- Skills for Care
- Stroke Association