NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Guideline scope

1 Guideline title

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

2 Remit and background

The National Institute for Health and Care Excellence (NICE) has been asked by the Department of Health (DH) to develop a guideline on the transition between inpatient hospital settings and community or care home settings for adults with social care needs. The guideline will cover both:

- admission to inpatient hospital settings from community or care home settings; and
- discharge from inpatient hospital settings to community or care home settings.

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

The guideline will be based on the best available evidence of effectiveness, including cost effectiveness. It will be relevant to: health and social care practitioners; health and social care providers (including the independent and voluntary sectors); commissioners; service users and their carers (including people who purchase their own care).

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

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

3 Need for the guideline

3.1 Key facts and figures

A guideline on the transition between inpatient hospital settings and community or care home settings is required because of the negative effects on service users and their families when problems occur during the process. These problems occur at both admission to, and discharge from, hospital.

A poor transition creates significant anxiety, leaving people uncertain about their diagnosis and support (Vetter 2003; Kydd 2008 and Ellins 2012). This is particularly true when someone's discharge from hospital is delayed (Auditor General 2003).

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

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

- for their future support needs to be assessed
- for the funding arrangements for their ongoing support to be finalised
- to complete their NHS care (for example, intermediate [bed-based] care)
- for a residential or nursing home place to become available
- for their short or long-term package of home-based care to be finalised
- for community equipment to be supplied
- because their home is unsuitable for them to return to

- because they or their family need to decide whether or not they are happy with the services they have been offered, following an assessment of ongoing needs
- owing to disputes between statutory agencies about who is responsible for someone's ongoing support or about an aspect of the discharge decision (NHS England, 2013).

Figures released in February 2014 show that on the last Thursday in January 2014, 2683 patients in acute care settings experienced a delayed transfer of care – and most of these incidents were attributed to the NHS. Hospital re-admissions are also, arguably, a result of a poor hospital discharge process (McCoy et al. 2007).

It is also important to note that uncoordinated hospital admissions and avoidable admissions to residential or nursing care from hospital are important examples of poor transitions.

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

3.2 Current practice

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

3.3 Policy and legislation

Under the Community Care (Delayed Discharges etc) Act (CCDDA, 2003), local authorities can be charged by NHS hospitals when someone's transfer of care is delayed and the delay is solely attributable to the local authority. In

practice, there are important variations about how the provisions of the Act are applied. For example, some local authorities and acute trusts have arranged to pool responsibility for delayed transfers of care and establish new integrated ways of working.

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

Recent national policy has focussed on increasing the range of alternatives to hospital care, for example, by investing in intermediate and other 'step up' and 'step down' support (bed-based facilities designed to aid discharge from, and prevent unnecessary admissions to, hospital). More recently, local authorities were given £859 million to improve the hospital/care and support interface (Department of Health 2012).

The following policies and legislation relating to transitions and integrated working have been published by the Department of Health or UK Government (not intended to be a comprehensive list):

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

4 What the guideline will cover

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

The guideline will cover both admissions into, and discharge from, inpatient hospital settings for adults with social care needs. In the guideline social care needs are defined as where an individual requires personal care and other practical assistance by reason of age, illness, disability, pregnancy, childbirth, dependence on alcohol or drugs, or any other similar circumstances. This is based on the definition of social care in the Health and Social Care Act 2012 (Section 65).

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

4.1 Who is the focus?

4.1.1 Groups that will be covered

All adults (age 18 and above) with identified social care needs, in transition between inpatient hospital settings and community or care home settings.

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

4.1.2 Groups that will not be covered

- Anyone under the age of 18.
- Adults moving between inpatient hospital settings and community or care home settings without social care needs.
- Adults moving between health or social care and another system, for example, the criminal justice system.

4.2 Setting(s)

4.2.1 Settings that will be covered

Inpatient hospital settings

- Inpatient hospital settings including intermediate care and inpatient rehabilitation units.

Care home settings

- All residential or nursing care homes, including hospices.

Community settings

Including:

- People's own homes and other housing, including temporary accommodation.
- Extra care housing (such as warden supported, sheltered or specialist accommodation).
- Shared Lives Scheme (formerly Adult Placement Scheme) living arrangements.
- Supported living.

4.2.2 Settings that will not be covered

- Non-inpatient health settings (including A&E, outpatients and day care).
- Inpatient mental health settings (except for specialist dementia beds in a general hospital - see section 4.3.2).

4.3 Activities

4.3.1 Key areas that will be covered

All aspects of care planning and provision involved in supporting someone's transition between inpatient hospital settings and community or care home settings for adults with social care needs. The activities listed in this section apply to both admission to and discharge from hospital as appropriate.

(a) Referral and assessment.

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

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

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

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

(f) Interventions, services and elements of care packages that support effective and timely transitions between hospital and community or care home settings. Examples include:

- short-term care to regain independence (reablement)
- longer-term rehabilitation
- telecare (technology that links people's homes with a monitoring centre that can respond to problems)
- housing support services to facilitate hospital discharge (including repairs and adaptations)
- therapeutic services including occupational therapy, physiotherapy and nutrition support
- services provided by the voluntary and community sector, such as befriending or transport services
- primary and community health services where they are combined with social care to improve transitions
- care and support at the end of life.

(h) Interventions and approaches to prevent or reduce readmissions to hospital within 30 days.

(i) The provision of 'step up' facilities (for example bed based intermediate care), where a person is transferring into inpatient hospital settings.

(j) Support for carers of service users in transition between inpatient hospital settings and community or care home settings.

(k) Learning and development, and support and supervision of staff working with service users in transition between inpatient hospital settings and community or care home settings.

4.3.2 Areas that will not be covered

- Care and support planning that is not specifically designed to support timely transition between inpatient hospital settings and community or care home settings.
- Care and support planning to prevent admissions to hospital that does not involve a move between settings. Admission avoidance that does not

specifically involve a transition between settings is much wider topic and is out of the scope of this guideline.

- Prevention of admissions to A&E (unless as part of a readmission to hospital within 30 days).
- Home care, unless it forms part of a care package intended to support a safe and timely transition. Where home care is covered, the focus would be on its availability and organisation to ensure a timely hospital discharge.
- Specialist inpatient and community mental health services. This is because services and arrangements for people in mental health settings are separate and subject to distinctive legislative and policy frameworks. (For example, care following discharge is subject to provisions set out under section 117 of the Mental Health Act. In addition, the Care Programme Approach has to be followed.) Transitions between inpatient mental health settings and community or care home settings will, therefore, be covered in a separate NICE guideline (referred). However, the experiences of people with mental health problems (including dementia) whose care and support transfers between general hospital and community or care home settings will be included in this guideline.

4.4 Main outcomes

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

- user and carer experience, views and satisfaction
- the emotional and psychological impact of transition between inpatient hospital settings and community or care home settings
- quality and continuity of care
- safety and adverse effects of poor transition planning
- safeguarding
- social support during transition
- levels of independence achieved by service users
- ability to carry out daily activities
- choice and control for services users and carers

- social care-related quality of life (for example, measured using the Adult Social Care Outcomes Toolkit, ASCOT)
- health-related quality of life
- suicide rates
- life years saved.

Service outcomes include:

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

4.5 Review questions

Review questions guide a systematic review of the literature. They address only the key issues covered in the scope and usually relate to interventions, service delivery or user and carer experience. Please note these are draft questions, which will be finalised by the Guideline Development Group at the start of guideline development.

4.5.1 What are the views and experiences of people using services and their carers in relation to the transition between inpatient hospital settings and community or care home settings?

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

4.5.3 What are the views of health, social care and housing practitioners about the transition between inpatient hospital settings and community or care home settings?

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

4.5.5 What is the effectiveness of interventions and approaches designed to improve hospital discharge?

4.5.6 What is the effectiveness of interventions and approaches designed to reduce or prevent hospital re-admissions within 30 days of hospital discharge?

4.5.7 What helps and what makes it difficult to ensure successful transitions between inpatient hospital settings and community or care home settings?

4.5.8 Which adults with social care needs are particularly vulnerable to the impact of a poor transition between inpatient hospital settings and community or care home settings?

4.5.9 What is the impact of specific interventions to support people with mental health problems during transition between general hospital and community or care home settings?

4.5.10 What is the impact of specific interventions to support people with end-of-life care needs during transition between inpatient hospital settings and community or care home settings?

4.5.11 How much unpaid care is provided by family and friends to support transitions between inpatient hospital settings and community or care home settings?

4.5.12 What impact does learning and development for health and social care staff have on transitions between inpatient hospital settings and community or care home settings?

4.6 Economic aspects

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

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

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

4.7 Status of this document

4.7.1 Scope

This is the final scope, incorporating comments from a 4-week consultation.

4.7.2 Timing

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

5 Related NICE guidance

5.1.1 Published guidance

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

5.1.2 Other related NICE guidance

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

5.2 Guidance under development

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

- Mental wellbeing of older people in care homes NICE quality standard, publication expected December 2013

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

5.3 NICE Pathways

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

6 Further information

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

7 References

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