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

**NICE guideline: short version**

**Draft for consultation, June 2015**

If you wish to comment on this version of the guideline, please be aware that all the supporting information and evidence is contained in the full guideline.

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## 1 Introduction

2 A range of health, social care and other services are involved when adults  
3 with care and support needs move into or out of hospital from community or  
4 care home settings. Families and carers also play an important part.

5 Problems can occur if services and support are not integrated, for example, if  
6 hospital admissions are not coordinated. This can result in delayed transfers  
7 of care, re-admissions, poor care and avoidable admissions to residential or  
8 nursing care. Hospital discharge problems also occur when people are kept  
9 waiting:

- 10 • for further, non-acute NHS care
- 11 • for their home care package to be finalised
- 12 • for community equipment
- 13 • because their home is unsuitable
- 14 • because of disputes between statutory agencies about who is responsible  
15 for their ongoing support.

16 Figures released by NHS England in March 2015 show that on 1 day in  
17 February, 3342 people were delayed in hospital.

18 This guideline covers all adults with identified social care needs, including  
19 older people. It does not include children and young people. It covers  
20 transitions between general hospital and community or care home settings. It  
21 does not include inpatient mental health settings. A separate NICE guideline  
22 on [transitions between inpatient mental health settings and community and  
23 care home settings](#) is being developed.

24 In the guideline social care needs are defined as where a person needs  
25 personal care and other practical assistance by reason of age, illness,  
26 disability, pregnancy, childbirth, dependence on alcohol or drugs, or any other  
27 similar circumstances. This is based on the definition of social care in the  
28 Health and Social Care Act 2012 (Section 65).

## DRAFT FOR CONSULTATION

1 This guideline considers how person-centred care and support should be  
2 planned and delivered during admission to, and discharge from, hospital. It  
3 addresses how services should work together and with the person, their family  
4 and carers, to ensure transitions are timely, appropriate and safe.

5 The guideline is for health and social care practitioners, health and social care  
6 providers, commissioners, people who use health and social care services  
7 and their carers (including people who purchase their own care).

8 This guideline has been developed in the context of a complex and rapidly  
9 evolving landscape of guidance and legislation, most notably the [Care Act](#)  
10 [2014](#). The Care Act and other legislation describe what organisations must  
11 do. This guideline focusses on 'what works', how to fulfil those duties and how  
12 to deliver care and support.

13 The Care Quality Commission use NICE guidelines as evidence to inform the  
14 inspection process and NICE quality standards to inform ratings of good and  
15 outstanding.

16

## 1 **Person-centred care**

2 This guideline assumes that the practitioners using it will read it alongside the  
3 [Care Act 2014](#). It is also written to reflect the rights and responsibilities that  
4 people and practitioners have as set out in the [NHS Constitution for England](#).

5 Care and support should take into account individual needs and preferences.  
6 People should have the opportunity to make informed decisions about their  
7 care, in partnership with health and social care practitioners. Practitioners  
8 should recognise that each person is an individual, with their own needs,  
9 wishes and priorities. They should treat everyone they care for with dignity,  
10 respect and sensitivity.

11 If someone does not have capacity to make decisions, health and social care  
12 practitioners should follow the [code of practice that accompanies the Mental](#)  
13 [Capacity Act](#) and the supplementary [code of practice on deprivation of liberty](#)  
14 [safeguards](#).

15 If the person using the service agrees, families and carers should have the  
16 opportunity to be involved in decisions about care and support. Families and  
17 carers should also be given the information and support they need in their  
18 own right. NICE has produced guidance on the components of good [patient](#)  
19 [experience in adult NHS services](#).

20

## 1 **Recommendation wording**

2 The Guideline Committee makes recommendations based on an evaluation of  
3 the evidence, taking into account the quality of the evidence and cost  
4 effectiveness.

5 In general, recommendations that an action 'must' or 'must not' be taken are  
6 usually included only if there is a legal duty (for example, to comply with the  
7 Care Act or health and safety regulations), or if the consequences of not  
8 following it could be extremely serious or life threatening.

9 Recommendations for actions that should (or should not) be taken use  
10 directive language such as 'agree', 'offer' 'assess', 'record' and 'ensure'.

11 Recommendations for which the quality of the evidence is poorer, or where  
12 there is a closer balance between benefits and risks, use 'consider'.

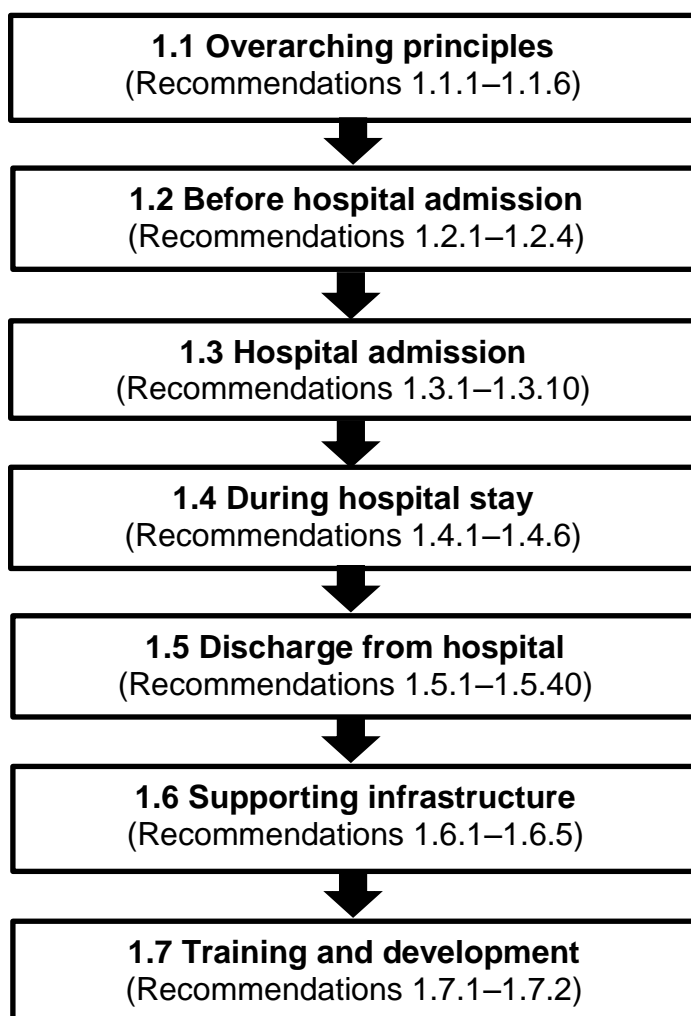
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# 1 Recommendations

2 The following guidance is based on the best available evidence. The [full](#)  
3 [guideline](#) [\[hyperlink to be added for final publication\]](#) gives details of the  
4 methods and the evidence used to develop the guidance.

## 5 **Summary of recommendations**

6 The recommendations in this guideline are divided into 7 key areas  
7 summarised in the diagram below. The recommendations in section 1.1 detail  
8 overarching principles of care for transition. The recommendations in sections  
9 1.2–1.5 focus on the actions that health and social care practitioners,  
10 providers and commissioners should take to ensure effective and coordinated  
11 care at each stage of the transition pathway; **before, during and after**  
12 **transition**. The recommendations in sections 1.6 and 1.7 focus on supporting  
13 infrastructure and training and development.



14

1 **1.1** ***Overarching principles of care and support during***  
2 ***transition***

3 **Person-centred care**

4 1.1.1 See everyone receiving care as an individual and an equal partner  
5 who can make choices about their own care. They should be  
6 treated with dignity and respect throughout their transition.

7 1.1.2 Identify and support people at risk of less favourable treatment or  
8 less access to services, for example people with communication  
9 difficulties or who misuse drugs or alcohol.

10 1.1.3 Involve families and carers in discussions about the care being  
11 given or proposed if the person gives their consent. If there is doubt  
12 about the person's capacity to consent, the principles of the [Mental](#)  
13 [Capacity Act](#) must be followed.

14 **Communication and information sharing**

15 1.1.4 Ensure that everyone involved in someone's move between  
16 hospital and their home is in regular contact with each other so that  
17 the transition is coordinated. For more information on  
18 communication needs see recommendation 1.1.2 in the NICE  
19 guideline on [patient experience in adult NHS services](#).

20 1.1.5 Information should be offered:

- 21
- 22 • verbally and in written format (in plain English)
  - 23 • in other formats that are easy for the person to understand, such  
as braille, [Easy Read](#) or translated material.

24 1.1.6 Give people information about their diagnoses and treatment when  
25 they are being transferred between hospital and home. If  
26 appropriate, also give this to their family and carers.



1 **1.2** ***Before admission to hospital***

2 1.2.1 Health and social care practitioners should develop a care plan for  
3 adults with identified social care needs who are at risk of being  
4 admitted to hospital. This should include contingency planning to  
5 help them manage their health condition. If they are admitted to  
6 hospital, health and social care practitioners should refer to this  
7 plan.

8 1.2.2 Assign a member of the community multidisciplinary team to  
9 coordinate support with the hospital multidisciplinary team for  
10 people with a long-term condition.

11 1.2.3 Health and social care practitioners and advocates should explain  
12 to the person what type of care they might receive and discuss  
13 advance care plans and contingency planning (see sections 1.3  
14 and 1.5 of NICE's guideline on [patient experience in adult NHS](#)  
15 [services](#)). Discussions might cover:

- 16 • place of care
- 17 • religion and spirituality
- 18 • daily routines
- 19 • managing risk
- 20 • how, when and where they receive information and advice
- 21 • the use of an advocate to support them when communicating  
22 their needs and preferences
- 23 • end-of-life care.

24 1.2.4 During end-of-life care, find out and record the person's wishes and  
25 those of their family and carers.

1 **1.3 Admission to hospital**

2 **Communication and information sharing**

3 1.3.1 Health and social care commissioners should encourage the use of  
4 communication protocols and procedures to support admissions.

5 These might include sharing of:

- 6 • lists of medicines in standard documentation
- 7 • contact details for the main carer
- 8 • contact details for next of kin
- 9 • end-of-life wishes.

10 1.3.2 The admitting team should identify and address people's  
11 communication needs at the point of admission. For more  
12 information on communication needs see recommendation 1.1.2 in  
13 the NICE guideline on [patient experience in adult NHS services](#).

14 1.3.3 Health and social care practitioners, including out-of-hours GPs,  
15 responsible for transferring people from the community into hospital  
16 should ensure the admitting team is given all relevant information.

17 This may include:

- 18 • advance care plans
- 19 • behavioural issues (triggers to certain behaviours)
- 20 • communication needs
- 21 • communication passport
- 22 • current medicines
- 23 • hospital passport
- 24 • housing status
- 25 • named carers
- 26 • other profiles containing important information about the  
27 person's needs and wishes
- 28 • preferred places of care.

1 1.3.4 For an emergency admission, A&E should ensure all relevant  
2 information is given to the admitting team, when a person is  
3 transferred for an inpatient assessment or to an admissions ward.

4 1.3.5 The admitting team should provide the person and their family with  
5 an opportunity to discuss their care. They should also provide them  
6 with the following information:

- 7 • reason for admission
- 8 • how long they might need to be in hospital
- 9 • care options and treatment they can expect
- 10 • when they can expect to see the doctors
- 11 • the name of the person who will be their contact
- 12 • how they might get home when they are discharged from  
13 hospital
- 14 • care and treatment after discharge.

15 1.3.6 The admitting team should identify whether there is a need for  
16 reasonable adjustments to be made to accommodate the person in  
17 hospital. For example, the team should ensure:

- 18 • there is enough space around the bed for wheelchair users to  
19 move from their bed to their chair.
- 20 • people with visual impairments know where the nurse call bell  
21 and emergency buzzer are
- 22 • there are adequate facilities for carers who stay with the person  
23 in hospital.

#### 24 **Establish a hospital-based multidisciplinary team**

25 1.3.7 As soon as the person is admitted to hospital, identify staff to form  
26 the hospital-based multidisciplinary team that will support them.  
27 They should work with the community-based multidisciplinary team.  
28 The composition of both teams should reflect the person's needs  
29 and circumstances.

30 Members of a hospital-based multidisciplinary team could include:

- 1 • doctor
- 2 • nurse
- 3 • physiotherapist
- 4 • occupational therapist
- 5 • mental health practitioner
- 6 • hospital pharmacist
- 7 • dietitian
- 8 • specialists in the person's conditions
- 9 • hospital social worker.

10 1.3.8 The hospital-based multidisciplinary team should provide  
11 coordinated support for older people, from hospital admission  
12 through to their discharge home.

### 13 **Assessment and care planning**

14 1.3.9 As soon as people with complex needs are admitted to hospital,  
15 intermediate care or step-up facilities, all relevant practitioners  
16 should start assessing their health and social care needs. They  
17 should also start discharge planning. If assessments have already  
18 been conducted in the community, refer to the person's existing  
19 care plan.

20 1.3.10 Start a comprehensive geriatric assessment of older people with  
21 complex needs at the point of admission and preferably in a  
22 specialist unit.

## 23 **1.4 *During hospital stay***

### 24 **Communication and information sharing**

25 1.4.1 Record multidisciplinary assessments, prescribed medicines and  
26 individual preferences in an electronic data system. Make it  
27 accessible to both the hospital- and community-based  
28 multidisciplinary teams, subject to information governance  
29 protocols.

1 1.4.2 At each shift handover and ward round, members of the hospital-  
2 based multidisciplinary team should review and update the  
3 person's progress towards hospital discharge.

4 1.4.3 Hospital-based practitioners should keep people regularly updated  
5 about any changes to plans for a person's transfer from hospital.

## 6 **Providing care**

7 1.4.4 Provide care for older people with complex needs in a specialist,  
8 geriatrician-led unit or on a specialist geriatrician-led ward.

9 1.4.5 Treat people admitted to hospital after a stroke in a stroke unit and  
10 offer them early supported discharge. (See recommendations 1.1.8  
11 and 1.1.9 in NICE's guideline on [stroke rehabilitation](#).)

12 1.4.6 Encourage people to follow their usual daily routines as much as  
13 possible during their hospital stay.

## 14 **1.5 Discharge from hospital**

### 15 **Discharge coordinator**

16 1.5.1 One health or social care practitioner should be responsible for  
17 coordinating the person's discharge from hospital. Create either a  
18 designated discharge coordinator post or make a member of the  
19 hospital- or community-based multidisciplinary team responsible.  
20 Select them according to the person's care and support needs. A  
21 named replacement should always cover their absence.

22 1.5.2 The discharge coordinator should be a central point of contact for  
23 health and social care practitioners, the person and their family,  
24 particularly during discharge planning. They should be involved in  
25 all decisions about discharge planning.

### 26 **Communication and information sharing**

27 1.5.3 Health and social care commissioners should agree clear  
28 discharge planning protocols.

1 1.5.4 Health and social care managers should ensure all health and  
2 social care practitioners receive regular briefings on the discharge  
3 planning protocols.

4 1.5.5 During discharge planning, the discharge coordinator should share  
5 assessments and updates on the person's health status, including  
6 medicines data, with both the hospital- and community-based  
7 multidisciplinary teams.

8 1.5.6 The hospital-based doctor responsible for the person's care should  
9 ensure the discharge summary is sent to the person's GP within  
10 24 hours of their discharge. They should also ensure a copy is  
11 given to the person the day they are discharged.

12 1.5.7 Make a member of the hospital-based multidisciplinary team  
13 responsible for providing carers with information and support. This  
14 could include:

- 15 • printed information
- 16 • face-to-face
- 17 • by phone
- 18 • hands-on training, including practical support and advice.

19 1.5.8 The discharge coordinator should provide people who need end-of-  
20 life care and their families with details of who to contact about  
21 medicine and equipment problems that occur in the 24 hours after  
22 discharge.

### 23 **Discharge planning: key principles**

24 1.5.9 Ensure continuity of care for people being transferred from hospital,  
25 particularly older people who may be confused or who have  
26 dementia. For more information on continuity of care see the  
27 recommendations in section 1.4 of NICE's guideline on [patient](#)  
28 [experience in adult NHS services](#).

1 1.5.10 Commissioners and providers should ensure people do not have to  
2 make decisions about long-term residential or nursing care while  
3 they are in crisis.

4 1.5.11 Hospital managers should try to ensure that any perceived or real  
5 pressures to make beds available do not result in unplanned and  
6 uncoordinated hospital discharges.

### 7 **Discharge planning**

8 1.5.12 From admission, or earlier if possible, the hospital- and community-  
9 based multidisciplinary teams should work together to identify and  
10 address factors that could prevent a safe, timely transfer of care  
11 from hospital. This could include:

- 12 • homelessness
- 13 • safeguarding issues
- 14 • suitable placement in a care home.

15 1.5.13 The discharge coordinator should work with the hospital- and  
16 community-based multidisciplinary teams and the person receiving  
17 care to develop and agree a discharge plan.

18 1.5.14 The discharge coordinator should ensure the discharge plan takes  
19 account of the person's social and emotional wellbeing, as well as  
20 the practicalities of daily living. It should include:

- 21 • details about the person's condition
- 22 • medicines management information (for more on medicines  
23 management for people in transition between settings see  
24 section 1.2 of NICE's guideline on [medicines optimisation](#))
- 25 • contact information after discharge
- 26 • arrangements for continuing social care support
- 27 • arrangements for continuing health support
- 28 • details of other useful community services.

- 1 1.5.15 The discharge coordinator should give the plan to the person and  
2 all those involved in their ongoing care and support, including  
3 families and carers (if the person agrees). The discharge  
4 coordinator should also arrange follow-up care.
- 5 1.5.16 The discharge coordinator should identify practitioners (from  
6 primary health, community health, social care and housing) and  
7 family members who will provide support when the person is  
8 discharged. Their details should be recorded in the discharge plan.
- 9 1.5.17 Once assessment for discharge is complete, the discharge  
10 coordinator should agree the plan for ongoing treatment and  
11 support with the community-based multidisciplinary team.
- 12 1.5.18 The discharge coordinator should discuss the need for any  
13 specialist equipment and support with primary health, community  
14 health, social care and housing practitioners as soon as discharge  
15 planning starts. This includes housing adaptations. Any specialist  
16 equipment and support should be in place at the point of discharge.
- 17 1.5.19 A relevant health or social care practitioner should discuss with the  
18 person how they can manage their condition after their discharge  
19 from hospital. They should provide support and education,  
20 including 'coaching' if needed. Make this available for carers as  
21 well as people using services.
- 22 1.5.20 Consider supportive self-management as part of a treatment  
23 package for people with depression or other mental health  
24 problems.

25 **Discharge planning for end-of-life care needs**

- 26 1.5.21 Commissioners should ensure both general and specialist palliative  
27 care services are available for people who have end-of-life care  
28 needs.



1 1.5.22 Health and social care practitioners should work together to ensure  
2 people needing end-of-life care are offered both general and  
3 specialist palliative services, according to their needs.

4 1.5.23 The named consultant responsible for a person's end-of-life care  
5 should consider referring them to a specialist palliative care team  
6 before they are transferred from hospital.

7 1.5.24 The discharge coordinator should ensure people who have end-of-  
8 life care needs are assessed and support is in place so they can  
9 die in their preferred place.

#### 10 **Early supported discharge**

11 1.5.25 Commissioners should ensure older people with identified social  
12 care needs are offered early supported discharge with a home care  
13 and rehabilitation package.

14 1.5.26 Consider commissioning early supported discharge with a home  
15 care and rehabilitation package provided by a community-based  
16 multidisciplinary team for adults with identified social care needs.

#### 17 **People at risk of hospital readmission**

18 1.5.27 The discharge coordinator should refer people at risk of hospital  
19 readmission to the relevant community-based health and social  
20 care practitioners before they are discharged. For example, if a  
21 person is homeless, the discharge coordinator should liaise with  
22 the local authority housing options team to ensure they are offered  
23 advice and help.

24 1.5.28 Health, social care and housing commissioners should ensure  
25 homeless people with social care needs are offered suitable  
26 temporary accommodation and support.

1 **Involving carers**

2 1.5.29 The hospital- and community-based multidisciplinary teams should  
3 treat the family as an important resource for understanding the  
4 person's life and needs.

5 1.5.30 With the person's agreement, include the family's views and wishes  
6 in discharge planning.

7 1.5.31 If the discharge plan involves support from family or carers, the  
8 hospital-based multidisciplinary team should take account of their:

- 9
- 10 • willingness and ability to provide support
  - 11 • circumstances, needs and aspirations
  - 12 • relationship with the person
  - 13 • need for respite.

14 1.5.32 In line with the [Care Act 2014](#), carers must be informed about their  
15 right to a carer's assessment.

16 **Support and training for carers**

17 1.5.33 Commissioners should ensure training is available to help carers  
18 provide practical support.

19 1.5.34 A member of the hospital-based multidisciplinary team should  
20 discuss the practical and emotional aspects of providing care with  
21 potential carers.

22 1.5.35 The relevant multidisciplinary team should offer family members  
23 and other carers of people who have had a stroke needs-led  
24 training in how to care for them. For example, this could include  
25 techniques to help someone carry out everyday tasks as  
26 independently as possible. Training might take place in hospital or  
27 it may be more useful at home after discharge.

28 1.5.36 The relevant multidisciplinary team should consider offering family  
members and other carers needs-led training in care for people

1 with conditions other than stroke. Training might take place in  
2 hospital or it may be more useful at home after discharge.

3 1.5.37 The community-based multidisciplinary team should review the  
4 carer's training and support needs regularly (as a minimum at the  
5 person's 6-month and annual reviews). The team should take into  
6 account that their needs may change over time.

### 7 **After transfer from hospital**

8 1.5.38 Community-based health and social care practitioners should  
9 maintain contact with the person after they are discharged. This  
10 could include regular phone calls and home visits. It also involves  
11 making sure the person knows how to contact them when they  
12 need to.

13 1.5.39 An appropriately skilled practitioner should follow up people with  
14 palliative care needs within 24 hours after their transfer from  
15 hospital.

16 1.5.40 A GP or community-based nurse should phone or visit people at  
17 risk of readmission 24–72 hours after their discharge.

## 18 **1.6 Supporting infrastructure**

19 1.6.1 Local health commissioners and local authorities should ensure a  
20 range of local services is available to support people on discharge  
21 from hospital. This might include:

- 22 • reablement: helping people re-learn some of the skills for daily  
23 living that they may have lost
- 24 • other intermediate care services
- 25 • practical support for carers.

26 1.6.2 Local health commissioners, hospital trusts and local authorities  
27 should have a multi-agency plan to address pressures on services,  
28 including bed shortages.

1 1.6.3 Local health commissioners should ensure all care providers,  
2 including GPs and out-of-hours providers, are kept up to date on  
3 the availability of local health and social care services.

4 1.6.4 Local health commissioners should ensure local protocols are in  
5 place so that out-of-hours providers have access to information  
6 about the person's preferences for end-of-life care.

7 1.6.5 Health and social care practitioners should be aware of the local  
8 community health, social care and third sector services available to  
9 support people during their move from hospital.

## 10 **1.7 Training and development**

11 1.7.1 Hospital trusts and local authorities should make sure their staff are  
12 trained in the hospital discharge process. Training should take  
13 place as early as possible, with regular updates. It could include:

- 14 • medicines management
- 15 • medicines adherence (for more information see NICE's guideline  
16 on [medicines adherence](#))
- 17 • medicines review in partnership with the person
- 18 • how to get information about the person's social and home  
19 situation (including who is available to support the person)
- 20 • discharge communications
- 21 • interdisciplinary working between the hospital- and community-  
22 based multidisciplinary teams, people using services and their  
23 carers
- 24 • learning how to assess the person's home environment (home  
25 visits)
- 26 • awareness of the local community health, social care and third  
27 sector services available to support people during their move  
28 from hospital to the community
- 29 • helping people to manage risks effectively so that they can still  
30 do things they want to do (risk enablement).

1 1.7.2 Consider making the training recommended in 1.7.1 available to  
2 community-based health and social care practitioners,  
3 physiotherapists and occupational therapists.

## 4 **2 Implementation: getting started**

5 NICE has worked with the Committee to identify areas in this draft guideline  
6 that may have a significant impact on practice and could be challenging to  
7 implement.

8 If the draft recommendations are not changed after consultation we think there  
9 will be cross-cutting challenges in 3 important areas of the guideline:

- 10 • Recognising that everyone receiving care is an individual and an equal  
11 partner who can make informed choices about their own care (related to  
12 recommendations 1.1.1, 1.1.2, 1.1.3 and 1.3.6).
- 13 • Developing effective communication and improving coordination of services  
14 (related to recommendations 1.1.6, 1.3.3 and 1.3.5).
- 15 • Changing working practices to improve planning for transitions in and out of  
16 hospital (related to recommendations 1.2.1 and 1.3.9).

17 During consultation we want stakeholders to let us know whether you agree.  
18 Or do you think other areas in this guideline will have a bigger impact – or be  
19 more difficult to implement?

20 We would also like you to send us your suggestions about how these  
21 challenges could be met. For example, you could share examples of good  
22 practice, or give us details of educational materials or other resources that you  
23 have found useful. This information will be used to write an implementation  
24 section for the final guideline.

25 Please use the [stakeholder comments form](#) to send us your comments and  
26 suggestions.

1 ***Challenges for implementation***

2 **Challenge 1 Recognising that everyone receiving care is an individual**  
3 **and an equal partner who can make informed choices about their own**  
4 **care**

5 See recommendations 1.1.1, 1.1.2, 1.1.3 and 1.3.6.

6 **Potential benefits of implementation**

7 People receiving care will benefit because they will experience care and  
8 support that suits their needs rather than the needs of services.

9 **Challenges**

10 For health and social managers this will mean ensuring that:

- 11 • Significant changes in practice take place in services where the decisions  
12 are made 'about' rather than 'with' people.

13 For health and social care practitioners this will mean ensuring that:

- 14 • Families and carers are involved in discussions about the person, if the  
15 person has given permission.  
16 • People who are at risk of less favourable treatment or less access to  
17 services (such as people who are homeless or with mental health  
18 problems) are identified and supported, and reasonable adjustments are  
19 made, to ensure that they can make informed choices

20 **Challenge 2 Developing effective communications and improving**  
21 **coordination of care**

22 See recommendations 1.1.6, 1.3.3, and 1.3.5.

23 **Potential benefits of implementation**

24 Good communications, both between health and social care practitioners  
25 working in multidisciplinary teams and between practitioners and the person,  
26 their family and carers, enable improved coordination of care and therefore a  
27 better experience for the person.

1 **Challenges**

2 For health and social care service managers this will mean ensuring that:

- 3 • Effective systems are in place so that practitioners are enabled to  
4 communicate successfully.

5 For health and social care practitioners this will mean ensuring that:

- 6 • The admitting team is given all relevant information and good  
7 communications are maintained throughout the hospital stay, discharge  
8 and after.  
9 • There is good communication with the person and, where appropriate, their  
10 family and carers.

11 **Challenge 3 Changing working practices to improve planning for**  
12 **transitions into and out of hospital**

13 See recommendations 1.2.1 and 1.3.9.

14 **Potential benefits of implementation**

15 Efficient admission and discharge planning enables a smooth transition that  
16 meets the person's specific needs and preferences.

17 **Challenges**

18 For health and social care practitioners this will mean ensuring that:

- 19 • the assessment and discharge planning process begins as soon as the  
20 person has been admitted to hospital (if this process hasn't already been  
21 included in an existing care plan).  
22 • people in the community at risk of being admitted to hospital have this  
23 recorded in a care plan and the plan is referred to when a person at risk is  
24 admitted to hospital.  
25 • all planning is person-centred

## 1 **3 Research recommendations**

2 The Guideline Committee has made the following research recommendations  
3 in response to gaps and uncertainties in the evidence identified from the  
4 evidence reviews. The Guideline Committee selected the key research  
5 recommendations that they think will have the greatest impact on people's  
6 care and support.

### 7 **3.1 *Training for hospital and social care practitioners***

8 What is the effect of hospital discharge or transitions training for health and  
9 social care practitioners on achieving successful transfers from hospital to  
10 home or the community? (Including specifically the effects on formal and  
11 informal carers, and on avoidable readmissions?)

#### 12 **Why this is important**

13 There is some evidence from US studies that training improves medical  
14 students' confidence in planning hospital discharge. It also shows that  
15 dedicated transitions training involving home visits helps medical and  
16 pharmacy students appreciate the person's home environment and how it  
17 may affect discharge decisions.

18 But the studies could not determine whether this translated into improved  
19 practice or outcomes for people using services. In addition, there is a lack of  
20 UK-based evidence on whether training improves people's experience of  
21 transitions from hospital to home or the community.

22 Comparative studies are needed on different approaches to training for social  
23 care staff, and on whether training improves outcomes for people using  
24 services and their carers.

25 Qualitative data are needed from home care commissioners and providers  
26 (including managers and frontline practitioners) about their perceptions and  
27 experiences of training. Interviews are also needed with people using services  
28 and their carers to gauge their views of the skills and competence of their  
29 support workers.



1    **3.2        *Self-management support for people with mental***  
2                    ***health problems***

3    Which interventions are effective in supporting self-management for people  
4    with mental health problems who also have a physical condition and are  
5    moving into and out of general inpatient hospital settings?

6    **Why this is important**

7    Current evidence on interventions that support self-management is  
8    contradictory and is specific to people with heart conditions. It is not clear  
9    whether certain types of support for people with mental health problems are  
10   more effective, acceptable to them, or preferred by them. Groups with  
11   different health or social care needs may need different approaches.

12   Research is needed on the effect of assessing mental health needs at  
13   admission and discharge for different populations. Detailed examination is  
14   needed of the components of effective interventions to discover what works,  
15   as well as how and for whom.

16   Data are also needed on the effectiveness of models of multiagency working  
17   and how GPs can support transitions from hospital to the community.

18   Qualitative studies gauging the views of people with mental health problems  
19   and their experiences of self-management support during transition could  
20   show which components of a self-management intervention are feasible and  
21   acceptable.

22   **3.3        *Mental health interventions to support discharge***  
23                    ***from general inpatient hospital settings***

24   What interventions are cost effective in supporting people with mental health  
25   problems on discharge from general hospital inpatient settings?

26   **Why this is important**

27   The only evidence found was 1 UK randomised controlled trial for frail older  
28   people with dementia or delirium. It showed no significant differences in

1 mortality or service outcomes, and did not consider community care resources  
2 or unpaid care.

3 Cost-effectiveness analyses are needed on interventions to support people  
4 with mental health problems discharged from hospital. This includes the cost  
5 of assessing needs while in hospital, including in specialist units.

6 This is particularly important for patients with dementia or delirium because  
7 earlier identification in hospital might lead to long-term cost savings for the  
8 public sector and society as a whole.

9 Research is needed on what measures are effective in preventing, managing  
10 or resolving dementia or delirium when a person is transferred. And on what  
11 training is most effective for hospital staff supporting people during transition.

12 Costs and outcomes for patients and carers need to be measured, including  
13 changes in mental health and carers' outcomes. Costs should include health  
14 and social care, unpaid care, and effects on employment and housing.

15 Studies are also needed for anxiety, depression and multimorbid mental  
16 illness.

### 17 **3.4 Geriatric assessment and care**

18 What is the cost-effectiveness of comprehensive geriatric assessment and  
19 care on specialist units compared with alternative models of care on general  
20 wards?

#### 21 **Why this is important**

22 Currently there is no UK evidence on the cost effectiveness of specialist  
23 geriatric assessment and care compared with standard, non-specialist care.

24 International evidence (mainly from the US) and evidence from the economic  
25 analysis carried out for this guideline suggest that care in a specialist unit is  
26 likely to be cost effective. But in England most older people – including those  
27 with complex needs – are treated on general wards.

1 It is important to establish the incremental cost and outcomes of provision by  
2 mobile teams working on general wards compared with specialist units. Costs  
3 need to reflect the use of health and social care resources (including in the  
4 community and care homes) as well as unpaid care.

5 Data are needed for costs and outcomes 6 to 12 months after discharge: the  
6 time horizon should be sufficient to measure the effects on mortality, hospital  
7 readmissions and care home admissions.

### 8 **3.5 Assessment at home to improve hospital discharge** 9 **success rates**

10 How effective are home assessment interventions and approaches designed  
11 to improve hospital discharge outcomes?

#### 12 **Why this is important**

13 Little research has been conducted in this area. There is a little evidence that  
14 older people find the hospital environment alienating because of the negative  
15 impact on their routine. One Australian qualitative study highlighted the  
16 challenge for occupational therapy if it is de-contextualised from normal life,  
17 but the findings could not be extrapolated to UK practice.

18 Randomised controlled trials are needed to compare the effectiveness of  
19 assessment in hospital with home assessment after discharge, from a social  
20 care needs perspective, for different populations. Information on patient- and  
21 cost-related outcomes is also needed.

22 Qualitative studies with people who were assessed at home could inform the  
23 design of future interventions, by exploring the feasibility and acceptability of  
24 home assessment compared with hospital assessment.

## 25 **4 Glossary**

### 26 **Advance care plan**

27 An advance care plan, which may result from discussions between a person,  
28 their care providers, and those close to the person, could include:

- 1 • an advance statement (a statement of wishes and preferences)
- 2 • an advance decision to refuse treatment
- 3 • appointing a personal welfare Lasting Power of Attorney.

#### 4 **Care plan**

5 An agreement between a person and a health professional (or social services)  
6 to help them manage their health day to day. It can be a written document or  
7 something recorded in patient notes.

#### 8 **Communication passport**

9 A communication passport draws together information on a person with  
10 communication difficulties: likes, dislikes, how they communicate, and how  
11 best to communicate with them (including the person's own views, as much as  
12 possible). It can be a book, video or collection of images that distils this  
13 information into a clear, positive and accessible format.

#### 14 **Community-based multidisciplinary team**

15 Members of a community-based multidisciplinary team could include:

- 16 • GP
- 17 • community nurse
- 18 • community mental health practitioner
- 19 • social worker
- 20 • housing officer
- 21 • community pharmacist.

#### 22 **Coaching**

23 Giving someone instructions to support them through hospital discharge, for  
24 example in medication management, or identifying possible triggers indicating  
25 deterioration in their condition and what to do about them.

#### 26 **Discharge plan**

27 A document that describes the coordination of care and support for discharge  
28 from hospital. It is a working document for the multidisciplinary teams.

1 **Discharge summary**

2 A summary of what happened during the admission and hospital stay from a  
3 medical perspective. Information might include diagnosis, the outcomes of  
4 investigations, changes to treatment and the medicines with which the person  
5 was discharged.

6 **Early supported discharge service**

7 A multidisciplinary service that aims to allow patients return home from  
8 hospital earlier than usual and receive more rehabilitation in their own home.

9 **Hospital passport**

10 A document for people who have a learning disability, which helps provide  
11 hospital staff with information for care planning and discharge arrangements.

12 **Intermediate care**

13 Care to help people avoid going into hospital, or to help them regain their  
14 independence after a hospital stay.

15 **Medicines management**

16 The safe and effective use of medicines to enable the best possible  
17 outcomes.

18 **Step-up facilities**

19 Intermediate care settings that receive patients from home or community  
20 settings to prevent unnecessary acute hospital admissions or premature  
21 admissions to long-term care.

22 **Supportive self-management**

23 Supportive self management is based on the principle that people should be  
24 active partners in their own health and wellbeing, rather than passive  
25 recipients of care. Health and social care practitioners teach self management  
26 techniques and help people build confidence to make informed decisions and  
27 achieve their health and social care related goals.

1 **5 Other information**

2 **5.1 Scope and how this guideline was developed**

3 NICE guidelines are developed in accordance with a [scope](#) that defines what  
4 the guideline will and will not cover.

**How this guideline was developed**

NICE commissioned the NICE Collaborating Centre for Social Care to develop this guideline. The Centre established a Guideline Committee (see section 5), which reviewed the evidence and developed the recommendations.

When this guideline was started we used the methods and processes described in the [Social care guidance manual \(2013\)](#). From January 2015 we used the methods and processes in [Developing NICE guidelines: the manual \(2014\)](#)

5

6 **6 The Guideline Committee, NICE Collaborating**  
7 **Centre and NICE project team, and**  
8 **declarations of interests**

9 **6.1 Guideline Committee**

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11 Person using services and carer

12 **Eileen Burns**

13 Consultant Physician and Honorary Senior Lecturer, Department of Medicine  
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15 **Paul Cooper**

16 Senior Operational Lead, Integrated Rehabilitation Service, Surrey County  
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8 **Margaret Lally**

9 Freelance consultant, various voluntary sector organisations

10 **Sandy Marks**

11 Person using services and carer

12 **Manoj Mistry**

13 Carer

14 **Rebecca Pritchard**

15 Director of Operations, Crisis

16 **Jill Scarisbrick**

17 Physiotherapist, Blackpool Fylde and Wyre NHS Trust; adult rehabilitation and  
18 neurology private practice

19 **Kathryn Smith (Chair)**

20 Director of Operations, Alzheimer's Society

21 **Kathleen Sutherland-Cash**

22 Person using services

23 **Geoff Watson**

24 Professional Lead for Social Work (Adults), Sirona Care and Health

1 **6.2** ***NICE Collaborating Centre for Social Care technical***  
2 ***team***

3 A technical team at the NICE Collaborating Centre for Social Care was  
4 responsible for this guideline throughout its development. It prepared  
5 information for the Guideline Committee, drafted the guideline and responded  
6 to consultation comments.

7 **Annette Bauer**

8 Economist, Personal and Social Services Research Unit, London School of  
9 Economics

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14 Guideline Programme Managers

15 **Anthony Gildea**

16 Guideline Project Manager

17 **Rita Parkinson and Anneka Patel**

18 Guideline Coordinators

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20 Technical Lead

21 **Tony Smith and Sarah Richards**

22 Economists

23 **Sue Jelley and Susie Burlace**

24 Editors

1 **6.4** *Declarations of interests*

2 The following members of the Guideline Committee made declarations of  
 3 interests. All other members of the Committee stated that they had no  
 4 interests to declare.

<b>Committee member</b>	<b>Interest declared</b>	<b>Type of interest</b>	<b>Decision taken</b>
Olivier Gaillemain	Interests are in improving the transition of care for frail older people.	Non-personal, non-pecuniary interest	None
Deborah Grieg	Employed full time by Gloucestershire County Council to undertake the role of Head of Adult Social Care in Gloucestershire Care Services NHS Trust (salaried post). Not a director of either organisation	Personal pecuniary interest	None
Deborah Grieg	Husband is employed full time in Gloucestershire Hospitals NHS Trust for which he receives a salary, he is not a Director	Personal family interest	None
Margaret Lally	While at the British Red Cross, contributed to documents on the need to improve transitional arrangements.	Non-personal pecuniary interest	None
Margaret Lally	A trustee of Heritage Care, a charity that provides independent living support for people with learning difficulties, people with mental health issues (through a subsidiary) and residential care for older people.	Non-personal pecuniary interest	None
Manoj Mistry	In February 2015 appointed a member of the Patient Panel at National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care, Greater Manchester.	Personal non-pecuniary interest	None
Manoj Mistry	In May 2015 appointed a member of the Study Steering Committee for the research project:	Non-personal pecuniary	None

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	'Comprehensive Longitudinal Assessment of Salford Integrated Care (CLASSIC): a study of the implementation and effectiveness of a new model of care for long term conditions' (University of Manchester/Salford Royal NHS FT).	interest	
Sandy Marks	Chair of Disability Action Islington, London.	Non-personal pecuniary interest	None
Sandy Marks	Co-chair of Making it Real board, London.	Non-personal pecuniary interest	None
Sandy Marks	Member of Integrated Care board of Islington Local Authority and Clinical Commissioning Group, London	Non-personal pecuniary interest	None
Sandy Marks	Chair of London Patient Voice.	Non-personal pecuniary interest	None
Sandy Marks	Father will benefit from the improvements the guideline aims to make.	Non-personal pecuniary interest	None
Manoj Mistry	In December 2014 appointed Public Representative Interviewer at the Medical School, Lancaster University.	Non-personal pecuniary interest	None
Manoj Mistry	In January 2015 appointed Public member of the NIHR's Research for Patient Benefit Programme Committee, Northwest Region.	Non-personal pecuniary interest	None
Manoj Mistry	Public private investment (PPI) representative for the Health Research Authority, London.	Non-personal pecuniary interest	None
Manoj Mistry	PPI representative for the Health Quality Improvement Partnership), London.	Non-personal pecuniary interest	None
Manoj Mistry	Lay member of NICE Clinical Guidelines Update Committee B.	Non-personal pecuniary	None

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		interest	
Manoj Mistry	PPI representative for the Primary Care Research in Manchester engagement Resource group at the University of Manchester.	Non-personal pecuniary interest	None
Manoj Mistry	Lay representative for the MSc in Clinical Bio Informatics at the University of Manchester.	Non-personal pecuniary interest	None
Manoj Mistry	Lay Educational Visitor at the Health and Care professions Council, London.	Non-personal pecuniary interest	None
Rebecca Pritchard	Involved in campaigning work on behalf of homeless people.	Non-personal pecuniary interest	None
Kathryn Smith	Director of Operations at the Alzheimer's Society and frequently asked to comment in the media on poor transitions between hospital and home.	Non-personal pecuniary interest	None
Kathleen Sutherland-Cash	Husband is employed regularly by an agency as a locum counselling psychologist for NHS mental health services	Personal family interest	None
Kathleen Sutherland-Cash	Work has involved challenging statutory authorities (NHS, Department for Work and Pensions and local councils) to ensure that disabled people's needs are met appropriately and policies and procedures are being correctly applied. Therefore involved in supporting disabled people to make formal complaints about appropriate health and social care practice and decisions.	Non-personal non-pecuniary interest	None
Kathleen Sutherland-Cash	Has asked MP to assist with issues relating to coordinatiing information and referral to local, regional and national hospitals for people with complex health conditions. Because the issues arising relate to cross	Personal and non-personal pecuniary interest	None

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	referral to numerous trusts, as well as access to the specialist services of the NHS as a whole, they can only be resolved by the Department of Health.		
Kathleen Sutherland-Cash	Involved in work representing the interests of people with learning difficulties.	Non-personal pecuniary interest	None

1