

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

NICE guideline

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[www.nice.org.uk/guidance/ng27](https://www.nice.org.uk/guidance/ng27)

## Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

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This guideline is the basis of QS136.

## Overview

This guideline covers the transition between inpatient hospital settings and community or care homes for adults with social care needs. It aims to improve people's experience of admission to, and discharge from, hospital by better coordination of health and social care services.

The Care Quality Commission uses NICE guidelines as evidence to inform the inspection process.

## *Who is it for?*

- Health and social care practitioners
- Health and social care providers
- Commissioners
- Service users and their carers (including people who purchase their own care)

## Recommendations

People using services have the right to be involved in discussions and make informed decisions about their care, as described in [your care](#).

[Making decisions using NICE guidelines](#) explains how we use words to show the strength (or certainty) of our recommendations, and has information about professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

### 1.1 *Overarching principles of care and support during transition*

#### Person-centred care

- 1.1.1 See everyone receiving care as an individual and an equal partner who can make choices about their own care. They should be treated with dignity and respect throughout their transition.
- 1.1.2 Identify and support people at risk of less favourable treatment or with less access to services for example, people with communication difficulties or who misuse drugs or alcohol. Support may include help to access advocacy.
- 1.1.3 Involve families and carers in discussions about the care being given or proposed if the person gives their consent. If there is doubt about the person's capacity to consent, the principles of the [Mental Capacity Act](#) must be followed.

#### Communication and information sharing

- 1.1.4 Ensure that the person, their [carers](#) and all health and social care practitioners involved in someone's move between hospital and home are in regular contact with each other. This is to ensure the transition is coordinated and all arrangements are in place. For more on medicines-related communication and medicines reconciliation during transitions, see sections 1.2 and 1.3 in NICE's guideline on [medicines optimisation](#) and section 1.3 in NICE's guideline on [managing medicines in care homes](#).
- 1.1.5 Give people information about their diagnoses and treatment and a complete list of their medicines when they transfer between hospital and home (including their care home). If appropriate, also give this to their family and carers.

1.1.6 Offer information in a range of formats, for example:

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

## 1.2 *Before admission to hospital*

1.2.1 Health and social care practitioners should develop a care plan with adults who have identified social care needs and who are at risk of being admitted to hospital. Include contingency planning for all aspects of the person's life. If they are admitted to hospital, refer to this plan.

1.2.2 If a [community-based multidisciplinary team](#) is involved in a person's care that team should give the hospital-based multidisciplinary team a contact name. Also give the named contact to the person and their family or [carer](#).

1.2.3 Health and social care practitioners and advocates should explain to the person what type of care they might receive. See sections 1.3 and 1.5 of NICE's guideline on [patient experience in adult NHS services](#). Discussions might cover:

- place of care
- religion, culture and spirituality
- daily routines (including the use of medicines and equipment)
- managing risk
- how, when and where they receive information and advice
- the use of an advocate to support them when communicating their needs and preferences
- advance care plans
- contingency planning
- end-of-life care.

## 1.3 Admission to hospital

### Communication and information sharing

- 1.3.1 Develop and use communication protocols and procedures to support admissions.
- 1.3.2 The admitting team should identify and address people's communication needs at the point of admission. For more information on communication needs see recommendation 1.1.2 in NICE's guideline on [patient experience in adult NHS services](#).
- 1.3.3 Health and social care practitioners, including care home managers and out-of-hours GPs, responsible for transferring people into hospital should ensure that the admitting team is given all available relevant information. This may include:
- advance care plans
  - behavioural issues (triggers to certain behaviours)
  - care plans
  - communication needs
  - communication passport
  - current medicines
  - hospital passport
  - housing status
  - named [carers](#) and next of kin
  - other profiles containing important information about the person's needs and wishes
  - preferred places of care.
- 1.3.4 For an emergency admission, A&E should ensure that all available, relevant information is given to the admitting team when a person is transferred for an inpatient assessment or to an admissions ward.

1.3.5 The admitting team should provide the person and their family, carer or advocate with an opportunity to discuss their care. Also provide the following information:

- reason for admission
- how long they might need to be in hospital
- care options and treatment they can expect
- when they can expect to see the doctors
- the name of the person who will be their main contact (this is not necessarily the discharge coordinator)
- possible options for getting home when they are discharged from hospital
- care and treatment after discharge.

1.3.6 The admitting team must identify whether there is a need for reasonable adjustments to be made to accommodate the person in hospital. This is in line with the [Equalities Act 2010](#). Examples include:

- providing communication aids (this might include an interpreter)
- ensuring there is enough space around the bed for wheelchair users to move from their bed to their chair
- appropriate adjustments for carers.

## Establishing a hospital-based multidisciplinary team

1.3.7 As soon as the person is admitted to hospital, identify staff to form the hospital-based multidisciplinary team that will support them. The composition of the team should reflect the person's needs and circumstances. Members could include:

- doctor
- nurse
- therapists



- mental health practitioner
- pharmacist
- dietitian
- specialists in the person's conditions
- social worker
- housing specialist
- voluntary sector practitioners.

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.

## Assessment and care planning

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

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

## 1.4 *During hospital stay*

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

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

1.4.3 Hospital-based practitioners should keep people regularly updated about any

changes to their plans for transfer from hospital.

- 1.4.4 Provide care for older people with complex needs in a specialist, geriatrician-led unit or on a specialist geriatrician-led ward.
- 1.4.5 Treat people admitted to hospital after a stroke in a stroke unit and offer them early supported discharge. (See recommendations 1.1.8 and 1.1.9 in NICE's guideline on stroke rehabilitation.)
- 1.4.6 Encourage people to follow their usual daily routines as much as possible during their hospital stay.

## 1.5 *Discharge from hospital*

### Discharge coordinator

- 1.5.1 Make a single health or social care practitioner responsible for coordinating the person's discharge from hospital. Create either designated discharge coordinator posts or make members of the hospital- or community-based multidisciplinary team responsible. Select them according to the person's care and support needs. A named replacement should always cover their absence.
- 1.5.2 Ensure that the discharge coordinator is a central point of contact for health and social care practitioners, the person and their family during discharge planning. The discharge coordinator should be involved in all decisions about discharge planning.

### Communication and information sharing

- 1.5.3 Health and social care organisations should agree clear discharge planning protocols.
- 1.5.4 Ensure that all health and social care practitioners receive regular briefings on the discharge planning protocols.
- 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.

- 1.5.6 The hospital-based doctor responsible for the person's care should ensure that the discharge summary is made available to the person's GP within 24 hours of their discharge. Also ensure that a copy is given to the person on the day they are discharged.
- 1.5.7 Make a member of the hospital-based multidisciplinary team responsible for providing carers with information and support. This could include:
- printed information
  - face-to-face meetings
  - phone calls
  - hands-on training, including practical support and advice.
- 1.5.8 The discharge coordinator should provide people who need end-of-life care, their families and carers with details of who to contact about medicine and equipment problems that occur in the 24 hours after discharge.
- 1.5.9 The discharge coordinator should consider providing people with complex needs, their families and carers, with details of who to contact about medicine and equipment problems that occur in the 24 hours after discharge.

## Discharge planning: key principles

- 1.5.10 Ensure continuity of care for people being transferred from hospital, particularly older people who may be confused or who have dementia. For more information on continuity of care see the recommendations in section 1.4 of NICE's guideline on patient experience in adult NHS services.
- 1.5.11 Ensure that people do not have to make decisions about long-term residential or nursing care while they are in crisis.
- 1.5.12 Ensure that any pressure to make beds available does not result in unplanned and uncoordinated hospital discharges.

## Discharge planning

- 1.5.13 From admission, or earlier if possible, the hospital- and community-based

multidisciplinary teams should work together to identify and address factors that could prevent a safe, timely transfer of care from hospital. For example:

- homelessness
- safeguarding issues
- lack of a suitable placement in a care home
- the need for assessments for eligibility for health and social care funding.

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

1.5.15 The discharge coordinator should ensure that the discharge plan takes account of the person's social and emotional wellbeing, as well as the practicalities of daily living. Include:

- details about the person's condition
- information about the person's medicines
- contact information after discharge
- arrangements for continuing social care support
- arrangements for continuing health support
- details of other useful community and voluntary services.

1.5.16 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).

1.5.17 The discharge coordinator should arrange follow-up care. They should identify practitioners (from primary health, community health, social care, housing and the voluntary sector) and family members who will provide support when the person is discharged and record their details in the discharge plan.

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.
- 1.5.20 A relevant health or social care practitioner should discuss with the person how they can manage their condition after their discharge from hospital. Provide support and education, including coaching, if needed. Make this available for carers as well as for people using services.
- 1.5.21 Consider supportive self-management as part of a treatment package for people with depression or other mental health difficulties.

### Discharge planning for end-of-life care needs

- 1.5.22 Ensure that people needing end-of-life care are offered both general and specialist palliative care services, according to their needs.
- 1.5.23 The named consultant responsible for a person's end-of-life care should consider referring them to a specialist palliative care team before they are transferred from hospital.
- 1.5.24 The discharge coordinator should ensure that people who have end-of-life care needs are assessed and support is in place so they can die in their preferred place.

### Early supported discharge

- 1.5.25 Ensure that older people with identified social care needs are offered early supported discharge with a home care and rehabilitation package.
- 1.5.26 Consider early supported discharge with a home care and rehabilitation package provided by a community-based multidisciplinary team for adults with identified social care needs.

## 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.
- 1.5.28 If a person is homeless, the discharge coordinator should liaise with the local authority housing options team to ensure that they are offered advice and help.

## Involving carers

- 1.5.29 The hospital- and community-based multidisciplinary teams should recognise the value of carers and families as an important source of knowledge about the person's life and needs.
- 1.5.30 With the person's agreement, include the family's and carer's views and wishes in discharge planning.
- 1.5.31 If the discharge plan involves support from family or carers, the hospital-based multidisciplinary team should take account of their:
- willingness and ability to provide support
  - circumstances, needs and aspirations
  - relationship with the person
  - need for respite.

## Support and training for carers

- 1.5.32 A member of the hospital-based multidisciplinary team should discuss the practical and emotional aspects of providing care with potential carers.
- 1.5.33 Ensure that training is available to help carers provide practical support. The relevant multidisciplinary team should offer family members and other carers of people who have had a stroke needs-led training in how to care for them. For example, this could include techniques to help someone carry out everyday tasks as independently as possible. Training might take place in hospital or it may be more useful at home after discharge.

- 1.5.34 The relevant multidisciplinary team should consider offering family members and other carers needs-led training in care for people with conditions other than stroke. Training might take place in hospital or it may be more useful at home after discharge.
- 1.5.35 The community-based multidisciplinary team should review the carer's training and support needs regularly (as a minimum at the person's 6-month and annual reviews). Take into account the fact that their needs may change over time.

## After transfer from hospital

- 1.5.36 Community-based health and social care practitioners should maintain contact with the person after they are discharged. Make sure the person knows how to contact them when they need to.
- 1.5.37 An appropriately skilled practitioner should follow up people with palliative care needs within 24 hours of their transfer from hospital to agree plans for their future care.
- 1.5.38 A GP or community-based nurse should phone or visit people at risk of readmission 24–72 hours after their discharge.

## 1.6 Supporting infrastructure

- 1.6.1 Ensure that a range of local community health, social care and voluntary sector services is available to support people when they are discharged from hospital. This might include:
- reablement (to help people re-learn some of the skills for daily living that they may have lost)
  - other intermediate care services
  - practical support for [carers](#)
  - suitable temporary accommodation and support for homeless people.
- 1.6.2 Have a multi-agency plan to address pressures on services, including bed shortages.

1.6.3 Ensure that all care providers, including GPs and out-of-hours providers, are kept up to date on the availability of local health, social care and voluntary services for supporting people throughout transitions.

1.6.4 Ensure that local protocols are in place so that out-of-hours providers have access to information about the person's preferences for end-of-life care.

## 1.7 *Training and development*

1.7.1 Ensure that all relevant staff are trained in the hospital discharge process. Training should take place as early as possible in the course of their employment, with regular updates. It could include:

- interdisciplinary working between the hospital- and community-based multidisciplinary teams, including working with people using services and their carers
- discharge communications
- awareness of the local community health, social care and voluntary sector services available to support people during their move from hospital to the community
- how to get information about the person's social and home situation (including who is available to support the person)
- learning how to assess the person's home environment (home visits)
- how to have sensitive discussions with people about end-of-life care
- medication review in partnership with the person, including medicines optimisation and adherence
- helping people to manage risks effectively so that they can still do things they want to do (risk enablement)
- how to arrange, conduct or contribute to assessments for health and social care eligibility.



## *Terms used in this guideline*

### **Carer**

A carer is someone who helps another person, usually a relative or friend, in their day-to-day life. This is not the same as someone who provides care professionally or through a voluntary organisation.

### **Coaching**

Giving someone instructions to support them through hospital discharge. For example in how to use their medicines effectively, or how to identify possible triggers that indicate their condition is deteriorating and what to do about it.

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

Members of a community-based multidisciplinary team could include:

- GP
- community nurse
- community mental health practitioner
- social worker
- housing officer
- voluntary sector practitioners
- community pharmacist
- therapists
- registered manager.

### **Comprehensive assessment of older people with complex needs**

A comprehensive geriatric assessment is an interdisciplinary diagnostic process to determine the medical, psychological and functional capability of someone who is frail and old. The aim is to develop a coordinated, integrated plan for treatment and long-term support.

## Older people

Generally this refers to people aged 65 years and over. But it could refer to people who are younger, depending on their general health, needs and circumstances.

For other social care terms see the Think Local, Act Personal [Care and Support Jargon Buster](#).

## Implementation: getting started

This section highlights 3 areas of the transition between inpatient hospital settings and community or care home settings for adults with social care needs guideline that were identified as a focus for implementation. It explains the reasons why the change needs to happen (given in the box at the start of each area). The section also gives information on resources and examples from practice to help with implementation.

### *The challenge: improving understanding of person-centred care*

See recommendations [1.1.1](#), [1.1.2](#), [1.1.3](#), [1.1.5](#), [1.3.3](#), [1.3.6](#), [1.4.6](#), [1.5.7](#), [1.5.14](#), [1.5.24](#), [1.5.29](#), [1.5.30](#), [1.5.31](#).

Providing person-centred care can ensure that:

- everyone with care and support needs is recognised as an individual and as an equal partner who can make informed choices about their own care
- when a hospital stay is needed, people who need care and support continue to experience a seamless service that suits their needs and meets their goals for care, rather than the needs of services
- **carers** are recognised for the understanding they bring about a person's life and preferences, and are given the support they need to sustain their own wellbeing
- practice is safe and effective, this in turn can reduce the long-term costs associated with poor quality care.

Managers and practitioners working in multidisciplinary hospital- and community-based teams need to develop a common understanding about person-centred care. That way they can better organise services around the needs of each person, especially as they transfer between care settings. But current pressures on services can mean that they feel unable to offer personalised care and support.

### What can health and social care managers and practitioners do to help?

- Use resources that focus on how to improve this area, such as:
  - those produced by [National Voices](#), a national coalition of charities that supports a strong patient and citizen voice and the [Think Local Act Personal](#) partnership

- – the Social Care Institute for Excellence's [Co-production in social care: what it is and how to do it](#).
- Chapter 7 of the [Care Act 2014: statutory guidance for implementation](#) if people need additional support. For example, if they need help from an advocate to make choices because they have communication difficulties or lack capacity and have no support from family, carers or friends.
- Use this guideline, along with the 'Care Act 2014: statutory guidance for implementation' and resources such as NHS England's [Commitment to carers](#), to understand your responsibilities towards carers in their own right, as well as the role that families and carers play in helping people making choices about their care.
- Use this guideline in local forums, and with national bodies involving health and social care practitioners, to review the knowledge, skills and competencies they need to provide person-centred care and support.
- Understand and consistently apply the [Accessible Information Standard](#) to provide information in formats that disabled people and, if appropriate, their carers and families, can understand. This standard will also help you ensure that people receive the right support to help them to communicate.

### *The challenge: ensuring health and social care practitioners communicate effectively*

See recommendations [1.1.4](#), [1.3.1](#), [1.3.2](#), [1.3.3](#), [1.4.1](#), [1.5.3](#).

Good communication systems enable:

- improved coordination of care and, therefore, a better experience for the person and improved outcomes
- practitioners to have a clear understanding about people's health, social care and support needs and preferences and the role practitioners need to play to promote wellbeing

They might also enable more efficient and cost-effective use of resources.

Poor coordination of care, and poor communication between and within teams, can lead to poorer outcomes and a poor experience of care. Local health and social care organisations need to establish communications protocols, procedures and systems. These should make best use of technology to enable data-sharing between all practitioners involved in the care and support of

people in the area (subject to information governance protocols).

Protocols for sharing information with people, their families and carers also need to be established to ensure that all communication arrangements are understood and used by all relevant practitioners.

## What can health and social care managers do to help?

- Understand the law on information sharing in health and social care and ensure staff are trained in the subject. See the Health and Social Care Information Centre's [Rules for sharing information](#) and the Care Quality Commission's [Code of practice on confidential personal information](#).
- Consider how practical examples of using technology and innovation to improve coordination can be applied locally, for example:
  - An electronic palliative care coordination system (EPaCCS) can help practitioners share a person's end-of-life care needs and preferences. [An economic evaluation of established EPaCCS early implementer sites](#) (by NHS Improving Quality) showed that these systems helped up to 80% of people who were included in the system to die in their place of choice. It was also claimed that EPaCCS saved the NHS money by reducing acute hospital admissions and bed use.
- Take forward proposals in the National Information Board's framework for action, [Personalised health and care 2020: using data and technology to transform the lives of patients and citizens](#). Use its case studies as examples. The aim is that all care records will be digital, real-time and interoperable by 2020. In the meantime, keep up to date with the Health and Social Care Information Centre's [Transfer of Care](#) initiative. This is testing improvements such as secure email between care homes and hospitals, standards for electronic discharge notices and improved use of technology in the home.

### *The challenge: changing how community- and hospital-based staff work together to ensure coordinated, person-centred support*

See recommendations [1.2.1](#), [1.2.2](#), [1.3.3](#), [1.3.7](#), [1.3.8](#), [1.5.1](#), [1.7.1](#).

Changing working practices across multidisciplinary teams is likely to lead to:

- a better experience of transitions between hospital and home and improved wellbeing for people with care and support needs, their carers and families

- greater job satisfaction
- more efficient and cost-effective use of resources

To achieve person-centred coordinated care for people moving between care settings may need changes in culture and local practice.

Managers need to assess the factors affecting integrated working in their areas, and motivate and support practitioners to adopt attitudes and behaviours that support person-centred approaches. Changing attitudes can be challenging, particularly if there are pressures on staff time and resources, and local capacity (or knowledge of alternative sources of support) is limited.

### What can health and social care managers do to help?

- Review local relationships across health, social care, housing and the voluntary sector and identify areas for improvement. Resources and organisations that can help include:
  - The Local Government Association, NHS England and their partners' resources and tools to improve integrated working through the Better Care Programme. The LGA's [Integration and the Better Care Fund](#) is a summary of programmes relating to integrated working for health and wellbeing boards, local authorities and their partners in the health and voluntary sectors. This includes the [Better Care Exchange](#), which offers the opportunity to share learning across systems, and a series of practice guides, such as [How to work together across health, care and beyond](#).
  - The Department of Health-funded [evaluation of the Homeless Hospital Discharge Fund](#) shows that joint working across sectors reduces delayed transfers of care for homeless people with social care needs.
  - The Social Care Institute for Excellence's [Dying at home: the case for integrated working](#) provides examples from practice, including case studies showing how working together can help to meet people's preferences.
- Establish a change programme that includes staff training based on the principles of the [Care Act](#) and the [Mental Capacity Act](#), and the ambitions set out in the [NHS Five Year Forward View](#). Depending on local needs and circumstances, the programme could draw on approaches identified in the Social Care Institute for Excellence's [Organisational change in social care study resource](#).

## *Need more help?*

Further resources are available from NICE that may help to support implementation.

- Annual indicators for use in the Quality and Outcomes Framework (QOF) for the UK. See the process and the NICE menu.
- Uptake data about guideline recommendations and quality standard measures.

## Context

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

Problems can occur if services and support are not integrated. For example, if hospital admissions are not coordinated. This can result in delayed transfers of care, re-admissions, poor care and avoidable admissions to residential or nursing care. Figures released by NHS England in August 2015 show that on 1 day in June, 5000 people were delayed in hospital.

Hospital discharge problems are reported to occur when people are kept waiting for:

- assessments of future care and support needs
- social services or NHS funding
- further non-acute NHS care (including intermediate care and rehabilitation services)
- nursing home placements
- residential home placements
- a care package in their own home
- community equipment and adaptations.

Hospital discharge problems can also occur because:

- the patient or family refuse the choice of services that have been offered
- statutory agencies disagree about readiness for discharge or responsibility for ongoing care.

In this guideline, a person with identified social care needs is defined as: someone needing personal care and other practical assistance because of their 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).

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



This guideline has been developed in the context of a complex, rapidly evolving landscape of guidance and legislation, most notably the [Care Act 2014](#).

In line with the Care Act, the guideline covers health and health-related provision (including housing), and other care and support. It focusses on 'what works', how to fulfil those duties and how to deliver care and support. This guideline does not include transitions involving mental health settings, see NICE's guideline on [transitions between inpatient mental health settings and community or care home settings](#).

## *More information*

You can also see this guideline in the NICE pathway on [transition between inpatient hospital settings and community or care home settings for adults with social care needs](#).

To find out what NICE has said on topics related to this guideline, see our web page on [care homes](#), [home](#) and [hospitals](#).

See also the guideline committee's discussion and the evidence reviews (in the [full guideline](#)), and information about [how the guideline was developed](#), including details of the committee.

## Recommendations for research

The guideline committee has made the following recommendations for research.

### *1 Training for hospital and social care practitioners*

What is the effect of hospital discharge or transitions training for health and social care practitioners on achieving successful transfers from hospital to home or the community, including the effects on formal and informal carers, and on avoidable readmissions?

#### Why this is important

There is a lack of UK evidence. There is some evidence from US studies that training improves medical students' confidence in planning hospital discharge. It also shows that dedicated transitions training involving home visits helps medical and pharmacy students appreciate the person's home environment and how it may affect discharge decisions. It does not show whether this translates into improved outcomes or systems.

Comparative studies on staff training are needed to examine which approaches improve outcomes for people and their carers, including safety and safeguarding. They should also examine whether training improves discharge systems and service level outcomes.

Qualitative data are needed from hospital and community practitioners involved in transitions (including managers and frontline practitioners) about their perceptions and experiences of training. Interviews and qualitative studies are needed with people using services and their carers to gauge their views of the skills and competence of practitioners.

The views of commissioners and provider organisations on their experiences of training are needed. A scoping study could identify the range and content of current training and ongoing support for practitioners involved in transitions. The outputs of this could inform future study design.

### *2 Self-management support for people with mental health difficulties*

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

## Why this is important

Current evidence is contradictory and is specific to people with heart conditions. It is not clear whether certain types of transition support is more effective for people with mental health difficulties or more acceptable or preferable from their point of view. Groups with different health or social care needs may need different approaches.

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

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

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

## *3 Mental health interventions to support discharge from general inpatient hospital settings*

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

## Why this is important

The only evidence found was 1 UK randomised controlled trial for frail older people with dementia or delirium. It showed no significant differences in mortality or service outcomes, and did not consider community care resources or unpaid care.

Cost-effectiveness analyses are needed to determine the cost of assessing this group's needs in hospital and in specialist units, and the cost of health and social care, unpaid care, and the effects on employment and housing.

Determining the cost of assessment while in hospital is particularly important for patients with dementia or delirium because early identification of difficulties might lead to long-term savings for the public sector and society.

Research is needed on what measures are effective in preventing, managing or resolving dementia

or delirium during transfer. Research is also needed on what training is most effective for hospital staff supporting people with mental health difficulties during the transition.

## *4 Geriatric assessment and care*

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

### **Why this is important**

Currently there is no UK evidence in this area.

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

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

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

## *5 Assessment at home to improve hospital discharge success rates*

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

### **Why this is important**

Little research has been conducted in this area. There is some evidence that older people find hospitals alienating because of the negative impact on their routine. One Australian qualitative study highlighted the challenge for occupational therapy if it is decontextualised from normal life, but the findings could not be extrapolated to UK practice.

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

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

## Glossary

### Advance care plan

An advance care plan could include:

- an advance statement (a statement of wishes and preferences)
- an advance decision to refuse treatment
- the appointment of a personal welfare Lasting Power of Attorney.

### Discharge plan

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

### Discharge summary

A summary of what happened during admission and the hospital stay from a medical perspective. It might include the diagnosis, outcomes of investigations, changes to treatment and the medicines started or stopped, or dosage changes and the reasons why.

### Early supported discharge

A multidisciplinary service that aims to allow patients to return home from hospital early and receive more rehabilitation support at home.

### Hospital passport

A document for people who have a learning disability. It provides hospital staff with information to help with care planning and discharge arrangements.

### Medication review

A structured, critical examination of a person's medicines. The aim is to agree the treatment with them, make sure the medication is being used effectively, minimise medication-related problems and reduce waste.

## Medicines optimisation

A person-centred approach to safe and effective medicines use, to ensure that people get the best possible outcomes. Covers both prescription and non-prescription medicines.

## Medicines reconciliation

Identifying the most accurate list of a person's current medicines – including name, dosage and frequency – and comparing them with the medicines the person is taking. The aim is to spot any discrepancies and document any changes to ensure that the list is complete, up to date and accurately communicated.

## Step-up facilities

Intermediate care settings that people are referred to from community settings. The aim is to prevent unnecessary acute hospital admissions or premature admissions to long-term care.

## Supportive self-management

Supportive self-management is based on the principle that people should be active partners in supporting their own health and wellbeing, rather than being passive recipients of care. Self-management techniques help people build the confidence to make informed decisions about their own health and social care and reach any related goals.

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## Accreditation

