NICE National Institute for Health and Care Excellence

NICE quality standard

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

Quality standard

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Contents

This standard is based on NG27.

This standard should be read in conjunction with QS2, QS13, QS30, QS85, QS86, QS117, QS123, QS132, QS153, QS159, QS171, QS173 and QS182.

Introduction

This quality standard covers admissions into, and discharge from, inpatient hospital settings for adults (18 and older) with social care needs. It does not include inpatient mental health settings because a separate quality standard will be produced on this topic.

Social care needs are defined as need for personal care and other practical assistance because of the person's 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).

For more information see the transition between inpatient hospital settings and community or care home settings for adults with social care needs topic overview.

Why this quality standard is needed

Several health, social care and other services are involved when adults with care and support needs move into or out of hospital from the community or a care home. Families and carers also play an important part.

Problems can occur if services and support are not integrated, resulting in delayed transfers of care, readmissions and poor care. Examples of poor transitions include discharge problems (such as when people are kept waiting for further non-acute NHS care or for their home care package to be finalised), uncoordinated hospital admissions and avoidable admissions to residential or nursing care from hospital.

NHS England's Delayed transfers of care statistics show that, in 2014/15, every day an average of 3.7 adults per 100,000 population had their transfer of care delayed. This is equivalent to over 1,500 delayed transfers a day throughout England. This is up from 3.1 per 100,000 in 2013/14.

Healthwatch England's Safely home: what happens when people leave hospital and care settings? report (2015) highlighted that poor hospital discharge practice leads to unnecessary problems for

patients and wasted resources.

In 2012/13 there were more than a million emergency readmissions within 30 days of discharge in England. This cost more than £2.4 billion (Emergency admissions to hospital: managing the demand National Audit Office).

The quality standard is expected to contribute to improvements in the following outcomes:

- health-related quality of life
- social care-related quality of life
- length of hospital stay
- delayed transfers of care
- hospital readmissions within 30 days of discharge.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable improvements in the 3 dimensions of quality – safety, experience and effectiveness of care – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 3 outcomes frameworks published by the Department of Health:

- Adult social care outcomes framework 2015–16
- NHS outcomes framework 2016–17
- Public health outcomes framework 2016–19.

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 Adult social care outcomes framework 2015–16

Domain	Overarching and outcome measures

1 Enhancing quality of life for people with care and support needs	*Overarching measure* 1A Social care-related quality of life** **People manage their own support as much as they wish, so they are in control of what, how and when support is delivered to match their needs** 1B Proportion of people who use services who have control over their daily life *Outcome measures* **Carers can balance their caring roles and maintain their desired quality of life** 1D Carer-reported quality of life**
2 Delaying and reducing the need for care and support	*Overarching measure* 2A Permanent admissions to residential and nursing care homes, per 100,000 population *Outcome measures* **Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs** **Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services** 2B Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services* 2D The outcomes of short-term services: sequel to service *Placeholder 2E The effectiveness of reablement services* **When people develop care needs, the support they receive takes place in the most appropriate setting and enables them to regain their independence** 2C Delayed transfers of care from hospital, and those which are attributable to adult social care

3 Ensuring that people have a positive experience of care and support	*Overarching measure* **People who use social care and their carers are satisfied with their experience of care and support services** 3A Overall satisfaction of people who use services with their care and support 3B Overall satisfaction of carers with social services *Placeholder 3E The effectiveness of integrated care* *Outcome measures* **Carers feel that they are respected as equal partners throughout the care process** 3C The proportion of carers who report that they have been included or consulted in discussions about the person they care for **People know what choices are available to them locally, what they are entitled to, and who to contact when they need help** 3D The proportion of people who use services and carers who find it easy to find information about support **People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual** This information can be taken from the Adult Social Care Survey and used for analysis at the local level

4 Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm	*Overarching measure* 4A The proportion of people who use services who feel safe** *Outcome measures* **Everyone enjoys physical safety and feels secure** **People are free from physical and emotional abuse, harassment, neglect and self-harm** **People are protected as far as possible from avoidable harm, disease and injuries** **People are supported to plan ahead and have the freedom to manage risks the way that they wish** 4B The proportion of people who use services who say that those services have made them feel safe and secure
Alignment with NHS outcomes framework and/or Public health outcomes framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

Table 2 NHS outcomes framework 2016–17

Domain	Overarching indicators and improvement areas

2 Enhancing quality of life for people with long-term conditions	*Overarching indicator* 2 Health-related quality of life for people with long-term conditions** *Improvement areas* **Reducing time spent in hospital by people with long-term conditions** 2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions **Enhancing quality of life for carers** 2.4 Health-related quality of life for carers** **Enhancing quality of life for people with dementia** 2.6 i Estimated diagnosis rate for people with dementia* *ii A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life* *** **Improving quality of life for people with multiple long-term conditions** *2.7 Health-related quality of life for people with three or more long-term conditions***
3 Helping people to recover from episodes of ill health or following injury	*Overarching indicators* 3a Emergency admissions for acute conditions that should not usually require hospital admission 3b Emergency readmissions within 30 days of discharge from hospital* *Improvement areas* **Helping older people to recover their independence after illness or injury** 3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation service* ii Proportion offered rehabilitation following discharge from acute or community hospital*

4 Ensuring that people have a positive experience of care	*Overarching indicators* 4a Patient experience of primary care i GP services ii GP Out-of-hours services 4b Patient experience of hospital care 4c *Friends and family test* *4d Patient experience characterised as poor or worse* *i Primary care* *ii Hospital care* ***Improvement areas*** **Improving hospitals' responsiveness to personal needs** 4.2 Responsiveness to inpatients' personal needs **Improving people's experience of accident and emergency services** 4.3 Patient experience of A&E services **Improving the experience of care for people at the end of their lives** 4.6 Bereaved carers' views on the quality of care in the last 3 months of life **Improving people's experience of integrated care** *4.9 People's experience of integrated care***
5 Treating and caring for people in a safe environment and protecting them from avoidable harm	*Overarching indicators* *5a Deaths attributable to problems in healthcare* *5b Severe harm attributable to problems in healthcare*
Alignment with Adult social care outcomes framework and/or Public health outcomes framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

Table 3 Public health outcomes framework for England 2016–19

Domain	Objectives and indicators
4 Healthcare public health and preventing premature mortality	*Objective* Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities *Indicators* 4.11 Emergency readmissions within 30 days of discharge from hospital* 4.13 Health-related quality of life for older people
Alignment with Adult social care outcomes framework and/or NHS outcomes framework * Indicator is shared	

Safety and people's experience of care

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to transitions between hospital and the community or a care home for adults with social care needs.

NICE has developed guidance and an associated quality standard on patient experience in adult NHS services (see the NICE pathway on patient experience in adult NHS services), which should be considered alongside this quality standard. They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and be supported to understand their options and make fully informed decisions. They also cover the provision of information to people using services. Quality statements on these aspects of patient experience are not usually included in topic-specific quality standards. However, recommendations in the development sources for quality standards that affect people's experience of using services and are specific to the topic are considered during quality statement development.

Coordinated services

The quality standard for transition between inpatient hospital settings and community or care home settings for adults with social care needs specifies that services should be commissioned from, and coordinated across, all relevant agencies. It also specifies they should encompass the whole care pathway. A person-centred, integrated approach to providing services is fundamental to

delivering high-quality care to adults with social care needs moving between hospital and the community or a care home.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality transition between hospital and the community or a care home are listed in related NICE quality standards.

Legislation and policy

This quality standard has been developed in the context of important legislative changes that have a significant impact on people with care and support needs moving between hospital and the community or a care home. The Care Act 2014 establishes new provisions as well as updating existing ones, bringing together relevant policy and guidance affecting people with care and support needs.

NHS England's Seven day services clinical standards set out principles for providing consistent high-quality urgent and emergency care in hospitals. The Emergency Care Improvement Programme's SAFER patient flow bundle aims to improve patient flow through adult inpatient wards.

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All health, public health and social care practitioners involved in assessing, caring for and treating adults with social care needs transitioning between hospital and the community or a care home should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development source on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

Role of families and carers

Quality standards recognise the important role families and carers have in supporting adults with social care needs moving between hospital and the community or a care home. If appropriate,

health and social care practitioners should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care. If someone does not have capacity to make decisions, health and social care practitioners should follow the code of practice that accompanies the Mental Capacity Act and the supplementary code of practice on deprivation of liberty safeguards.

List of quality statements

Statement 1. Adults with social care needs who are admitted to hospital have existing care plans shared with the admitting team.

Statement 2. Older people with complex needs have a comprehensive geriatric assessment started on admission to hospital.

Statement 3. Adults with social care needs who are in hospital have a named discharge coordinator.

Statement 4. Adults with social care needs are given a copy of their agreed discharge plan before leaving hospital.

Statement 5. Adults with social care needs have family or carers involved in discharge planning if they are providing support after discharge.

Quality statement 1: Information sharing on admission

Quality statement

Adults with social care needs who are admitted to hospital have existing care plans shared with the admitting team.

Rationale

Improved communication between community and hospital services leads to a smoother transition. For example, people who are admitted to hospital and their families or carers do not have to keep repeating the same information to different people. It can also improve people's experience of hospital because the admitting team is given a range of information about their needs, wishes and circumstances.

Quality measures

Structure

Evidence of local arrangements to ensure that existing care plans for adults with social care needs are shared with the admitting team when they are admitted to hospital.

Data source: Local data collection.

Process

The proportion of adults with social care needs who have existing care plans shared with the admitting team when they are admitted to hospital.

Numerator – the number in the denominator where the person's existing care plans are shared with the admitting team.

Denominator – the number of hospital admissions of adults with social care needs.

Data source: Local data collection.

Outcome

People's experience of hospital admission.

Data source: Local data collection.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (such as hospitals, GPs, community services and local authorities) ensure that systems are in place to transfer existing care plans for adults with social care needs to the admitting team when they are admitted to hospital. This may include the use of Summary Care Records, hospital passports or other profiles containing important information about the person's needs and wishes.

Health and social care practitioners (such as care home managers, GPs and social workers) ensure that they share existing care plans with the admitting team when they arrange a hospital admission for adults with social care needs.

Commissioners (clinical commissioning groups, local authorities and NHS England) ensure that they commission services in which adults with social care needs have existing care plans shared with the admitting team when they are admitted to hospital. This may include the use of Summary Care Records, hospital passports or other profiles containing important information about the person's needs and wishes.

What the quality statement means for patients and carers

Adults with social care needs know that, when they go into hospital, all the necessary information about them will be given to the hospital team.

Source guidance

- Transition between inpatient hospital settings and community or care home settings for adults with social care needs (2015) NICE guideline NG27, recommendation 1.3.3

Quality statement 2: Comprehensive geriatric assessment

Quality statement

Older people with complex needs have a comprehensive geriatric assessment started on admission to hospital.

Rationale

Older people make up a significant proportion of hospital admissions and many have complex medical, functional, psychological and social needs. Carrying out a comprehensive assessment helps practitioners to develop a long-term plan to manage those needs. This could reduce the length of hospital stay and help people regain their independence sooner and maintain it for longer.

Quality measures

Structure

Evidence of local arrangements to ensure that older people with complex needs have a comprehensive geriatric assessment started on admission to hospital.

Data source: Local data collection.

Process

Proportion of older people with complex needs who have a comprehensive geriatric assessment started on admission to hospital.

Numerator – the number in the denominator where a comprehensive geriatric assessment is started on admission to hospital.

Denominator – the number of hospital admissions of older people with complex needs.

Data source: Local data collection.

Outcome

a) Length of hospital stay for older people with complex needs.

Data source: Local data collection.

b) Delayed transfers of care for older people with complex needs.

Data source: Local data collection. National Delayed transfers of care data is published by NHS England.

c) Permanent admissions to residential and nursing care homes in the 12 months after hospital admission.

Data source:Local data collection. National data on permanent admissions to residential or nursing care are available as part of the Adult social care outcomes framework – indicator 2A.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (hospitals) ensure that systems are in place to start comprehensive geriatric assessments when older people with complex needs are admitted to hospital.

Health and social care practitioners (such as geriatricians) ensure that they start a comprehensive geriatric assessment when older people with complex needs are admitted to hospital.

Commissioners (clinical commissioning groups) ensure that they commission services in which older people with complex needs have a comprehensive geriatric assessment started when they are admitted to hospital. For emergency admissions, this supports NHS England's Seven day services clinical standards, standards 2 and 3.

What the quality statement means for patients and carers

Older people with complex needs have a thorough review of their needs when they go into hospital. This is done by healthcare professionals with specialist knowledge in caring for older people. The aim is to make a long-term plan to provide the support they need after they leave hospital.

Source guidance

- Transition between inpatient hospital settings and community or care home settings for adults with social care needs (2015) NICE guideline NG27, recommendation 1.3.10

Definitions of terms used in this quality statement

Older people with complex needs

Older people who need a lot of support because of physical frailty, chronic conditions or multiple impairments (including dementia). Many will be affected by other factors linked to poverty, disadvantage, nationality, ethnicity and lifestyle. Older people are generally people who are 65 or older, but could include people who are younger, depending on their general health, needs and circumstances.

The presence of 1 or more of the following in older people should trigger a comprehensive geriatric assessment:

- falls
- immobility
- delirium and dementia
- polypharmacy
- incontinence
- end of life care.

[Adapted from NICE's guideline on transition between inpatient hospital settings and community or care home settings for adults with social care needs, British Geriatric Society (2012) Quality care for older people with urgent and emergency care needs: 'The silver book' and Joseph Rowntree Foundation (2013) A better life: valuing our later years]

Comprehensive geriatric assessment

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.

[NICE's guideline on transition between inpatient hospital settings and community or care home settings for adults with social care needs, glossary]

Quality statement 3: Coordinated discharge

Quality statement

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

Rationale

Poor coordination related to plans for leaving hospital can result in distress and reduced quality of life for people using services and their carers. Making a single health or social care practitioner responsible for coordinating discharge can help to make the transition smoother (for example, this person can liaise with community services to arrange follow-up care). The discharge coordinator should be involved in discharge planning from admission, and throughout the person's hospital stay.

Quality measures

Structure

Evidence of local arrangements to ensure that adults with social care needs who are in hospital have a named discharge coordinator.

Data source: Local data collection.

Process

Proportion of discharges from hospital of adults with social care needs where there is a named discharge coordinator.

Numerator – the number in the denominator where there is a named discharge coordinator.

Denominator – the number of discharges from hospital of adults with social care needs.

Data source: Local data collection.

Outcome

a) Delayed transfers of care for adults with social care needs.

Data source:Local data collection. National Delayed transfers of care data is published by NHS

England.

b) Experience of the discharge process for adults with social care needs.

*Data source:*Local data collection.

c) Readmission rates for adults with social care needs.

*Data source:*Local data collection. National data on emergency readmissions within 30 days of discharge from hospital are available from the NHS Digital Indicator Portal as part of the NHS outcomes framework – indicator 3b.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (hospitals) ensure that systems are in place so that adults with social care needs have a named discharge coordinator.

Health and social care practitioners (for example, members of the hospital-based multidisciplinary team) ensure that they involve the discharge coordinator in all decisions about discharge planning for adults with social care needs.

Commissioners (clinical commissioning groups) ensure that they commission services that provide a named discharge coordinator for adults with social care needs.

What the quality statement means for patients and carers

Adults with social care needs who are in hospital are given the name of the person who will be responsible for coordinating their discharge. This person will work with the adult, and their family or carers, to plan their move out of hospital.

Source guidance

- Transition between inpatient hospital settings and community or care home settings for adults with social care needs (2015) NICE guideline NG27, recommendation 1.5.1

Definitions of terms used in this quality statement

Discharge coordinator

A single, named health or social care practitioner responsible for coordinating the person's discharge from hospital. A discharge coordinator may be a designated post or the task may be assigned to a member of the hospital- or community-based multidisciplinary team. They should be chosen according to the person's care and support needs. A named replacement should always cover their absence.

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.

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

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.

They should arrange the details of follow-up care, discuss the need for any specialist equipment and support with community services and, once assessment for discharge is complete, agree the plan for ongoing treatment and support with the community-based multidisciplinary team.

[Adapted from NICE's guideline on transition between inpatient hospital settings and community or care home settings for adults with social care needs, recommendations 1.5.1, 1.5.2, 1.5.5, 1.5.14, 1.5.17, 1.5.18 and 1.5.19]

Equality and diversity considerations

Barriers to communication can hinder people's understanding of transitions and how they can be involved in discharge planning. These barriers could include: learning or cognitive difficulties; physical, sight, speech or hearing difficulties; or difficulties with reading, understanding or speaking English. Adjustments should be made to ensure all adults with social care needs can work with the discharge coordinator on plans for their discharge and follow-up care, if they have the capacity to do so.

Quality statement 4: Discharge plans

Quality statement

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

Rationale

The discharge plan is an important part of a coordinated discharge process. To ensure adults with social care needs have a positive experience of this process, they need to understand and agree their own discharge plan, if they have the capacity to do so. If the person chooses to share the plan with everyone involved with their ongoing care and support this can lead to successful transfers and reduce the chance of hospital readmission.

Quality measures

Structure

Evidence of local arrangements to ensure that adults with social care needs are given a copy of their agreed discharge plan before being leaving hospital.

Data source: Local data collection.

Process

Proportion of discharges from hospital of adults with social care needs that include the person being given a copy of their agreed discharge plan before leaving hospital.

Numerator – the number in the denominator where the person is given a copy of their agreed discharge plan before leaving hospital.

Denominator – the number of discharges from hospital of adults with social care needs.

Data source: Local data collection. The Care Quality Commission's Adult Inpatient Survey gives national data.

Outcome

a) Readmission rates for adults with social care needs.

Data source:Local data collection. National data on emergency readmissions within 30 days of discharge from hospital are available from the NHS Digital Indicator Portal as part of the NHS outcomes framework – indicator 3b.

b) The experience of discharge from hospital for adults with social care needs.

Data source: Local data collection.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (hospitals) ensure that systems are in place for adults with social care needs to be given a copy of their agreed discharge plan before they leave hospital.

Health and social care practitioners (discharge coordinators and members of the hospital- and community-based multidisciplinary teams) ensure that they give a copy of the agreed discharge plan to adults with social care needs before they leave hospital.

Commissioners (clinical commissioning groups) ensure that they commission services in which adults with social care needs are given a copy of their agreed discharge plan before leaving hospital. This supports NHS England's Seven day services clinical standards, standard 1.

What the quality statement means for patients and carers

Adults with social care needs are given a copy of the plan for their move out of hospital before they leave. The plan should be easy for them to read and understand, and people giving them this information should also offer to explain it to them.

Source guidance

- Transition between inpatient hospital settings and community or care home settings for adults with social care needs (2015) NICE guideline NG27, recommendation 1.5.16

Definitions of terms used in this quality statement

Discharge plan

A document that describes the coordination of care and support for discharge from hospital. It is in addition to a discharge summary that is sent to a person's GP on discharge. It is a working document for the multidisciplinary teams. A discharge plan should take account of the person's social and emotional wellbeing, as well as the practicalities of daily living. It should include:

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

The discharge plan should also include a complete, accurate list of their medicines, including any changes made to medicines during their hospital stay. This includes information about when to take the medicine, correct dosage and an explanation of what it is for.

The discharge plan should be shared with the adult and all those involved in their ongoing care and support, if the adult agrees. All the information, including information about medicines, should be in a format that is easy for the person to understand.

[Adapted from NICE's guidelines on transition between inpatient hospital settings and community or care home settings for adults with social care needs (glossary, recommendations 1.1.2, 1.1.6, 1.5.15 and 1.5.16) and medicines optimisation (recommendation 1.2.4), and expert opinion]

Equality and diversity considerations

The discharge plan should be provided in a format that suits people's needs and preferences and meets the requirements set out in NHS England's Accessible Information Standard.

Barriers to communication can hinder people's understanding of transitions and how they can be involved in discharge planning. For example, these barriers can include: learning or cognitive difficulties; physical, sight, speech or hearing difficulties; or difficulties with reading, understanding or speaking English.

Adjustments should be made to overcome these barriers and ensure all adults with social care needs can be involved in making decisions about their discharge and follow-up care, if they have the capacity to do so. Support for people with communication difficulties may include access to advocacy services.

Quality statement 5: Involving carers in discharge planning

Quality statement

Adults with social care needs have family or carers involved in discharge planning if they are providing support after discharge.

Rationale

Families and carers can play a significant role in helping adults with social care needs return home after a hospital admission. It is therefore important that they are involved in decisions about the person's discharge plan, if they and the person agree. They can provide information about the person's needs and circumstances beyond medical conditions or physical needs. This means discharge planning can be more comprehensive and may reduce the likelihood of the person being readmitted to hospital.

Quality measures

Structure

Evidence of local arrangements to ensure that adults with social care needs have family or carers involved in discharge planning if they are providing support after discharge.

Data source: Local data collection.

Process

Proportion of discharges from hospital of adults with social care needs where family or carers are involved in discharge planning if they are providing support after discharge.

Numerator – the number in the denominator where family and carers are involved in discharge planning.

Denominator – the number of discharges from hospital of adults with social care needs where family or carers are providing support after discharge.

Data source: Local data collection.

Outcome

a) Delayed transfers of care for adults with social care needs.

Data source:Local data collection. National Delayed transfers of care data is published by NHS England.

b) Readmission rates for adults with social care needs.

Data source:Local data collection. National data on emergency readmissions within 30 days of discharge from hospital are available from the NHS Digital Indicator Portal as part of the NHS outcomes framework – indicator 3b.

c) Family and carer satisfaction with involvement in discharge planning for adults with social care needs.

Data source:Local data collection.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (hospitals) ensure that systems are in place to enable adults with social care needs to have family or carers involved in discharge planning if they are providing support after discharge.

Health and social care practitioners (such as discharge coordinators and members of the hospital-based multidisciplinary team) ensure that adults with social care needs have family or carers involved in discharge planning if they are providing support after discharge.

Commissioners (clinical commissioning groups) ensure that they commission services in which adults with social care needs have family or carers involved in discharge planning if they are providing support after discharge. This supports NHS England's Seven day services clinical standards, standard 1.

What the quality statement means for patients and carers

Adults with social care needs have family or carers involved in planning their move out of hospital if they are going to provide them with support at home.

Source guidance

- Transition between inpatient hospital settings and community or care home settings for adults with social care needs (2015) NICE guideline NG27, recommendation 1.5.30

Definitions of terms used in this quality statement

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.

[NICE's guideline on transition between inpatient hospital settings and community or care home settings for adults with social care needs]

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See how to use quality standards for more information, including advice on using quality measures.

Levels of achievement

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

NICE's quality standard service improvement template helps providers to make an initial assessment of their service compared with a selection of quality statements. It includes assessing current practice, recording an action plan and monitoring quality improvement. This tool is updated monthly to include new quality standards.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in development sources.

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments are available.

Good communication between health, public health and social care practitioners and adults with social care needs transitioning between hospital and the community or a care home is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Adults with social care needs transitioning between hospital and the community or a care home should have an interpreter or advocate made available if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

Development sources

Further explanation of the methodology used can be found in the quality standards process guide.

Evidence sources

The document below contains recommendations from NICE guidance that were used by the quality standards advisory committee to develop the quality standard statements and measures.

- Transition between inpatient hospital settings and community or care home settings for adults with social care needs (2015) NICE guideline NG27

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- Care Quality Commission (2016) Building bridges, breaking barriers: integrated care for older people
- Emergency Care Improvement Programme (2016) SAFER patient flow bundle
- Department of Health (2016) Care and support statutory guidance
- NHS Improving Quality (2016) Seven day services clinical standards
- Healthwatch England (2015) Safely home: what happens when people leave hospital and care settings?
- NHS England (2015) Delayed transfers of care statistics for England 2014/15 Annual Report
- Nuffield Trust (2015) Focus on: hospital admissions from care homes
- British Medical Association (2014) Hospital discharge: the patient, carer and doctor perspective
- Department of Health (2014) Care and support statutory guidance
- Department of Health (2013) Identifying the ordinary residence of people in need of community care services
- Royal College of Physicians (2013) Future hospital: caring for medical patients

- Age UK (2012) Right care, first time: services supporting safe hospital discharge and preventing hospital admission and readmission
- Department of Health (2012) National framework for NHS continuing healthcare and NHS funded nursing care
- Royal Pharmaceutical Society (2012) Keeping patients safe when they transfer between care providers – getting the medicines right

Definitions and data sources for the quality measures

- NHS England (2016) Delayed transfers of care
- NHS Digital (2015) Adult social care outcomes framework. Indicator 2A: Permanent admissions to residential and nursing care homes, per 100,000 population
- NHS Digital (2013) Indicator Portal NHS outcomes framework. Indicator 3b: Emergency readmissions within 30 days of discharge from hospital
- Care Quality Commission (2015) Adult Inpatient Survey

Related NICE quality standards

Published

- Social care for older people with multiple long-term conditions (2016) NICE quality standard 132
- Home care for older people (2016) NICE quality standard 123
- Medicines optimisation (2016) NICE quality standard 120
- Preventing excess winter deaths and illness associated with cold homes (2016) NICE quality standard 117
- Falls in older people (2015) NICE quality standard 86
- Medicines management in care homes (2015) NICE quality standard 85
- Dementia: independence and wellbeing (2013) NICE quality standard 30
- Patient experience in adult NHS services (2012) NICE quality standard 15
- End of life care for adults (2011) NICE quality standard 13
- Stroke in adults (2010) NICE quality standard 2

In development

- Transition between inpatient mental health settings and community or care home settings. Publication expected August 2017.

Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Consultant review within 12 hours of admission.
- Long-term conditions, people with comorbidities, complex needs.
- Medicines management: managing the use of medicines in community settings for people receiving social care.

- Readmissions.
- Regaining independence (reablement): short term interventions to help people to regain independence.

The full list of quality standard topics referred to NICE is available from the quality standards topic library on the NICE website.

Quality standards advisory committee and NICE project team

Quality standards advisory committee

This quality standard has been developed by quality standards advisory committee 2. Membership of this committee is as follows:

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The following specialist members joined the committee to develop this quality standard:

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About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

The methods and processes for developing NICE quality standards are described in the quality standards process guide.

This quality standard has been incorporated into the NICE pathway on transition between inpatient hospital settings and community or care home settings for adults with social care needs.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

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Endorsing organisation

This quality standard has been endorsed by Department of Health and Social Care, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Care and Repair England

- Headway - the brain injury association
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Physicians
- Healthwatch England
- Association of Disabled Professionals