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, QS85, QS86, QS117, QS123, QS132, QS153, QS159, QS171, QS173, QS182, QS184, QS187 and QS191.

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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured and can be adapted and used flexibly.

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 different audiences

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.

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. NICE guideline NG27 (2015), 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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured and can be adapted and used flexibly.

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 data is published in NHS England's Delayed transfers of care.

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 different audiences

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.

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. NICE guideline NG27 (2015), 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, terms used in this guideline, British Geriatric Society (2012) Silver book: quality care for older people with urgent and emergency care needs and Joseph Rowntree Foundation (2013) A better life: valuing our later years, full report]

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, terms used in this guideline]

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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured and can be adapted and used flexibly.

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 data is published in NHS England's Delayed transfers of care.

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 different audiences

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.

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. NICE guideline NG27 (2015), 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 and 1.5.17 to 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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that adults with social care needs are given a copy of their agreed discharge plan before 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 different audiences

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.

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. NICE guideline NG27 (2015), 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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured and can be adapted and used flexibly.

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 data is published in NHS England's Delayed transfers of care.

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 different audiences

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.

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. NICE guideline NG27 (2015), 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]

Update information

Minor changes since publication

February 2022: Sources for the definition of older people with complex needs in statement 2 were updated.

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.

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, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standards advisory committees for details about our standing committees. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the

quality statements are highlighted in each statement.

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.

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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 (RCGP)
- Royal College of Nursing (RCN)
- Royal College of Physicians (RCP)
- Healthwatch England
- Association of Disabled Professionals