NICE National Institute for Health and Care Excellence

Transition between health and social care scope
Stakeholder Comments proforma

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Stakeholder organisation:	**National Voices**
Date proforma submitted:	**11th February 2014**
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Comment No.	Section number Indicate **number** or **'general'** if your comment relates to the whole document	Comments Please insert each new comment in a new row. Please do not paste other tables into this table, as your comments could get lost – type directly into this table Proforma that are not correctly completed may be returned to you
1	General	The current title of the scope suggests a wider focus than the challenges surrounding hospital discharge alone. It would be useful to understand if focus is reflective of the nature of the evidence base in this area, or if the evidence base has been identified in line with this initial focus. If the scope will remain focused on this specific area, it would be advisable to make this focus clearer upfront. There is also an inherent risk that the current wording implies that the transition between health and social care will predominantly take place following an acute episode. This runs against the wider policy drive towards more proactive and prevention-focused care in the community.
2	General	The wording of the scope seems to suggest in some places that transitions occur at a single point in time, and in one direction. This is often not the case and not reflective of the complexity of ongoing interactions between health and social care where people often have multiple and complex needs.

3	General	The draft scope highlights that a lack of integration is a key factor in delayed discharge. The sections on current practice and policy make it clear previous processes have often been focussed on 'who is to blame' for the delay and penalties that result from this responsibility. These approaches have not been conducive to the promotion of more collaborative working. They have also focused on how the person can be 'moved around' the system within certain timescales, rather than focusing on individual outcomes and how health and social care services can best work together to support their return to the community. The growing drive for integration is moving away from health and social care being viewed as separate entities that come together at a specific point in time. Bearing in mind the timescales for the development of this guideline, it would be good to ensure that it is 'futureproofed' in relation to the likely direction of travel. Already it is clear that areas that are advancing their coordinated care plans are likely to 'co-locate' their health and social care teams, or even to bring them together with other professionals in multi-disciplinary teams. Recent reports suggest the Better Care Fund application process is further stimulating local authorities and CCGs in some areas to consider pooling whole budgets for health and social care. In finalising the scope of these guidelines, we have an opportunity to ensure that professionals focus on how we can improve how 'transitions' are experienced from the point of view of the person, rather than from a service perspective. The Narrative for person-centred, coordinated care, sets out what person-centred, coordinated care, across health and social care, would look and feel like to someone experiencing it. This has been drawn up in collaboration with people who use services and a range of national stakeholders. This includes a specific section on transitions, looking at the importance of contingency planning, the person feeling confident about what will happen next, and having a main point of contact throughout the process. By approaching the issue in this way, the 'transition' from a hospital setting to the community can be seen in a more holistic way, as part of a person's 'journey' to living and staying as well as possible, rather than as an isolated event.

4	4.1.2	We are disappointed to see that the draft scope of the document means that anyone under the age of 18 is not covered explicitly. Developing recommendations for adults and then 'considering their applicability to children' – as though children are just 'little adults' – does not seem appropriate. Again there is a need to take account of the direction of travel whereby, for example, children with special educational needs will soon be entitled to a combined 'education, health and care plan'. The issue of transfer for children from health into social care is an important one. It should be clarified how this will be considered as part of the process of developing the guideline and ensure that the additional factors that are particularly relevant to a child's development, health and wellbeing, such as access to education, play and leisure, are taken into account.
5	4.3.1(b) and (e)	As part of the activities covered, it might be useful to consider where the role of a care and support partner (an individual who works with a person on their care and support planning) fits into these discussions. As part of our work on care and support planning (referenced below) we have explored the key competencies of such a role and identified how they would help to coordinate care and facilitate communication between the wider team of professionals and supporters working with the person. In such circumstances, such a person could play a role in providing a connection between any care and support that was provided prior to hospital admission and work with the person and any secondary care professionals to consider if and how this care and support may need to change following their return to the community.
6	4.3.1(d) and 4.3.1(i)	The document currently recognizes 'self-directed support and use of a personal budget, based on a jointly agreed social care plan' as an activity that is in scope. We would like to see recognition of the growing potential of joint personal budgets, agreed via joint care and support planning processes across health and social care, in supporting better transitions back into a community setting. This may also have implications for people where coexisting health and social needs may be met in a more coordinated way, following discharge (e.g. a personal assistant could be trained to change dressings)

7	4.3.1 (g)	It might be useful to consider including the role of emergency support plans in preventing readmissions to hospital within 28 days. Research by NV members, the MS Society, has shown that effective emergency support planning can help to prevent hospital readmissions. For example, throughout 2010 the MS Society supported East Sussex County Council in piloting an innovative relapse support service. The County Council provided each person on the pilot scheme with a small sum of money. They were able to determine what support would be best for them in the event of a relapse, which could potentially result in a hospital admission, and to choose when to purchase this support. Each individual completed a relapse support plan detailing the type of support they would like to use if they have a relapse. The service enabled people to feel secure, knowing that support would be readily available if and when they needed it. This pilot showed that by having information upfront on what options are available if an individual has a sudden change in their condition can make a real difference to an individual's sense of control and can support a person to effectively meet their needs and avoid hospital readmission.
8	4.3.2	Currently it is suggested that 'care planning and provision that does not directly impact on the transition between health and social care' should not be in scope. We would like to clarify what elements of care planning and provision would not be relevant to consider when preparing for hospital discharge. When someone if preparing to leave hospital, it is important that the outcomes of any previous care and support planning discussions are taken into account. This will allow the person and the professional(s) involved to consider the person's return to the community in the broadest possible way and anticipate what types of support might be necessary to ensure that they retain the skills, confidence and knowledge to live as independently as possible. Care and support planning and timely transition planning are key mechanisms to ensure that the person and their family or carers stay central to discussions and planning decisions at all times. National Voices and partners are also increasingly moving towards the wording 'care and support planning' and this recognizes the language from both health and social care and signals that discussions are both about what care can be arranged for the person, and what actions they may be able to take themselves to stay and live well. The latter may often include connecting to support within the local community, which will be particularly important to prevent any potential issues resulting from social isolation. We are currently creating a public facing guide which sets out what good care and support planning should look like. More information about this project can be found here. The final version of the guide will be launched in early March.

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Closing date: 11 February 2014 at 5pm

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