

Working together for safer discharge to care homes

Impact, Learning and Next Steps Report



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Executive summary

Background

Care homes play a vital role in supporting residents, including those with complex health and care needs such as frailty, dementia and other long-term conditions. Despite caring for people, often with high levels of dependency, care homes frequently operate with a relatively small workforce and limited resources.

Transitions between hospitals and care homes can be complex, and feedback from both hospitals and care homes has highlighted a range of challenges associated with discharge processes. These include communication, information sharing, assessment processes and broader partnership working. The *Hospital to Care Home Discharge Improvement Campaign* was established to strengthen understanding and collaboration between hospital and care home staff, promote greater parity between health and social care, and support advocacy for elderly residents across South East London.

Ambition of the project

The project aimed to improve understanding, collaboration and partnership working between hospital and care home staff, whilst increasing awareness of care home services. The longer-term ambition is to support more consistent, person-centred and integrated care across South East London.

Describing the intervention

Discovery phase

- From October 2025 to March 2026, analysis of relevant data, guidance and policies was completed alongside engagement with care home managers, care home nurses, hospital staff and wider stakeholders to better understand the challenges associated with discharge from hospital to care homes.

Campaign

- Based on the learning from the discovery phase an awareness campaign was designed. This phase included co-design of key messages and discussion themes.

Ward visits

- To engage with staff, the project team visited 26 elderly care wards across Guy's and St Thomas' NHS Foundation Trust, Lewisham and Greenwich NHS Trust, King's College Hospital NHS Foundation Trust and Oxleas NHS Foundation Trust.
- Visits included structured discussions with over 200 ward staff (primarily nursing teams) and ad-hoc conversations.
- Care home representatives and other stakeholders participated in the visits, helping to facilitate shared learning, discuss challenges and identify improvements.

Feedback collection and evaluation

- Staff feedback was collected during the visits via a feedback form which captured understanding and perceived learning using Likert scale and open-ended questions. Quantitative data were analysed and qualitative responses considered thematically.
- The campaign received consistently positive feedback from ward and care home staff. Ninety-seven per cent of respondents reported learning 'a little' or 'a lot' as a result of participating in the visits.
- Feedback indicated increased awareness of the campaign's key messages, particularly in relation to communication, information sharing and discharge processes (feedback received is presented in [section 4.2](#)). Qualitative feedback



demonstrated strong support for closer partnership working between hospitals and care homes, with many staff identifying changes they would actively make themselves to improve communication and discharge planning.

Conclusion

Feedback received demonstrates that a targeted awareness and engagement campaign can improve understanding and collaboration between hospital and care home staff. The campaign helped strengthen the foundations for more effective partnership working going forward. As a result of bringing people together there was a renewed commitment from many staff to take practical steps to improve communication, information sharing and discharge planning. Continued partnership working, alongside progressing the actions and recommendations informed by the campaign, provides opportunities to make discharges safer and more consistent.

Findings, next steps and recommendations

The findings, actions and recommendations informed by the campaign are shown below.

What did we learn?	What will we do next?	Recommendations
Finding	Action(s)	
1. Open and clear communication between organisations and teams enables safe, consistent and efficient discharge.	Support exchange of information between staff: ○ Elderly care ward key contacts. ○ Care home information (e.g. nursing / residential/ mixed, bed numbers, key specialities) and escalation contact(s).	Hospital ward and care home staff should be empowered to communicate openly and to proactively address issues.
2. Discharge works best when there is trust and understanding between system partners.	Host a strategic discussion to explore opportunities for ward and care home nurses to gain experience across both settings, including supernumerary shifts.	Hospital ward and care home staff should continue to invest in relationship-building activity.
3. Different care homes and wards often had different processes and documentation for patient assessments leading to inefficiency.	Co-develop and share SEL principles for assessment to minimise variation and promote good practice.	Hospital ward and care home staff should routinely communicate the most important operational requirements in the assessment process e.g. sharing preferred assessment timeslots.
4. Care home staff do not always have access to discharge information recorded in digital patient records.	Identify the barriers to adoption of London Care Record (LCR) and Universal Care Plan (UCP) - high-level only. Then engage with London and ICB digital leads to understand available support and strategic plans for care homes.	Care homes, digital leads and system partners should support access to digital patient information and systems wherever possible, informed by patient need.
5. There is value in cascading learning from the campaign with all those involved in discharging patients from hospitals to care homes.	Explore development of a resource designed to provide hospital staff with an understanding of the realities of working in a care home.	Hospital leads should share key messages from the campaign with other staff groups and hospital departments.



Chapter 1. Introduction

Context

Safe and effective discharge from hospital is a key priority for the NHS, local authorities and care providers across South East London (SEL). Care homes play a vital role in supporting people, often with complex health and care needs, including frailty, dementia, multiple long-term conditions and end of life care. However, transitions between hospital and care homes involve multiple organisations, professionals and processes, creating opportunities for variation, communication challenges and delays. Evidence gathered through stakeholder engagement and data review within SEL identified a range of issues affecting hospital to care home discharge, including inconsistent communication, variation in local processes, information-sharing challenges, equipment delays and limited opportunities for care home and hospital staff to develop shared understanding of one another's roles and responsibilities.

The national policy context increasingly emphasises the importance of improving discharge, strengthening integration between health and social care, and delivering more care closer to home. The Government's Fit for the Future: The 10 Year Health Plan for England, published in 2025, highlights that people living in care homes and those living with frailty often experience poor outcomes when care is poorly coordinated and may be admitted to hospital unnecessarily. The plan also identifies improved patient flow, discharge processes and stronger collaboration between health and social care professionals as key priorities for the future NHS.

Alongside the 10 Year Health Plan, the NHS ambition to develop neighbourhood-based models of care places increasing emphasis on integrated working across organisational boundaries. The emerging Neighbourhood Health Service model seeks to reduce avoidable admissions, improve coordination of care and enable people to receive more personalised support closer to home through integrated neighbourhood teams. National guidance specifically recognises that care homes will be an important part of these arrangements and that health and care professionals must be able to work effectively across different care settings.

The importance of partnership working with care homes has also been reinforced through the Enhanced Health in Care Homes (EHCH) framework. The framework sets out a proactive, collaborative model of care in which NHS organisations, local authorities and care homes work together to improve outcomes for residents. It places a particular emphasis on information sharing, multidisciplinary working, personalised care planning and coordinated support across organisational boundaries.

Within South East London, hospital discharge remains a significant area of focus. Better Care Fund plans across the six boroughs identify discharge and admission avoidance as priorities and include metrics relating to discharge delays and long-term admissions to residential and nursing care. Further to this, across the system there is an ambition for greater parity between health and social care. This is underpinned by a commitment to taking a 'one workforce' approach to drive greater efficiency and better joined up patient care.



Background

This project is underpinned by work to better understand the challenges associated with hospital to care-home discharge across SEL. This included structured interviews with Transfer of Care leads, engagement with Skills for Care, Continuing Healthcare colleagues and care home stakeholders, together with broad analysis of data relating to discharge delays, quality alerts, care home activity and access to the London Care Record. The outcome of this was the identification of clear, recurring themes of communication, process variation, quality and governance, alongside opportunities to strengthen relationships between care home and hospital teams.

The discovery work also identified evidence of wider pressures affecting the system. Data showed over 8,300 ambulance incidents originating from care homes across SEL within a 12-month period, with approximately 73% resulting in conveyance to hospital. In addition, discharge datasets demonstrated that residential and nursing home arrangements were frequently identified among the leading causes of delayed discharge within acute trusts. These findings reinforced the importance of improving collaboration and highlight the acuity and dependency of care home residents.

Against this backdrop, the Hospital to Care Home Discharge Improvement Campaign was developed. This aimed to improve understanding, collaboration and partnership working between hospital and care home staff, whilst increasing awareness of care home services and challenging common misconceptions. The longer-term ambition is to support more consistent, person-centred and integrated care across South East London. This report considers the impact of the campaign, summarises the learning generated, and identifies recommendations and actions for future focus.

For this report, definitions and explanations of abbreviations used are provided in the [glossary](#).



Chapter 2. Ambition of the project

The ambition of the project was to improve discharge experiences and outcomes for residents by strengthening understanding, collaboration and partnership working between hospitals and care homes across South East London. The project was underpinned by the recognition that greater parity between health and social care is required to support safe, effective and person-centred care.

The project aimed to improve discharge between hospitals and care homes by:

1. Promoting parity between the NHS and social care sectors.
2. Increasing inclusion, recognition and support for care home staff.
3. Advocating for the needs of frail and vulnerable residents across South East London.

2.1 Ambition for Residents

For residents to:

- Experience safe, timely and person-centred discharge from hospital to care homes.
- Benefit from improved communication and coordination between hospital and care home teams.
- Experience fewer delays and avoidable issues during transitions of care.

2.2 Ambition for staff

For staff to:

- Feel recognised, valued and included as equal partners within the wider health and care system.
- Experience improved communication and information sharing during discharge.
- Have greater opportunities to contribute to service improvement and system learning.
- Strengthen discharge planning, communication and information sharing.
- Build trusted relationships with colleagues in different organisations and roles to support better resident outcomes.

2.3 Ambition for the System

For the system to:

- Improve integration and partnership working between health and social care.
- Identify and implement data- and intelligence-led improvement opportunities.
- Support safe and high-quality discharge and reduce unwarranted variation.
- Improve patient and staff experiences.
- Contribute to wider priorities relating to neighbourhood health, hospital flow, discharge improvement and care closer to home.

2.4 Ambition of the Evaluation

The evaluation aims to:

- Assess the impact of the campaign on staff awareness and understanding.
- Evaluate the extent to which the campaign strengthened relationships between hospital and care home staff.
- Identify learning arising from the campaign and capture recommendations and priorities for future discharge improvement activity across South East London.



Chapter 3. Describing the project

The project was designed as a practical awareness and engagement intervention aimed at improving understanding of care homes and hospital to care home discharge processes. The approach was informed by the ambitions of promoting parity between health and social care, recognising the contribution of care home staff, and advocating for frail and vulnerable residents across South East London.

The project was based on the premise that improving understanding of the roles, challenges and responsibilities of both hospital and care home staff would strengthen communication, trust and partnership working. In turn, improved collaboration would support safer, more consistent discharge processes and contribute to wider ambitions for integrated, person-centred care.

The approach was to combine awareness raising, relationship building and quality improvement, aiming to generate both immediate learning and longer-term improvements across the health and care system.

3.1 Discovery Phase

An initial discovery phase was undertaken between October 2025 and March 2026 to better understand the challenges associated with hospital to care home discharge across South East London. This involved engagement with Transfer of Care leads, care home representatives, Skills for Care, Continuing Healthcare colleagues and other system stakeholders. In addition, *desk research* was completed involving review of data, documents and policies. The key data sources which were analysed were discharge data, quality alerts, London Ambulance Service data and data showing care home logins to the London Care Record.

The discovery phase identified a number of recurring challenges, including:

- Communication and information-sharing issues between hospitals and care homes.
- Variation in discharge processes across organisations and boroughs.
- Challenges relating to discharge planning, assessments and equipment provision.
- Limited opportunities for hospital and care home staff to understand each other's roles and operating environments.
- Opportunities to make better use of data, intelligence and shared learning to inform improvement activity.

3.2 Hospital to Care Home Discharge Improvement Campaign

Key messages

To make the campaign impactful and focused, a campaign logo and set of key messages were co-produced with care homes, hospital teams and system partners. These messages incorporated learning from the discovery phase.





Figure 1: Campaign posters.

3.3 Ward visits

The campaign was delivered through structured visits to elderly care wards across four South East London NHS trusts - Guy's and St Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust, Lewisham and Greenwich NHS Trust and Oxleas NHS Foundation Trust

In total, 26 wards were visited (schedule is provided in [appendix 4](#)). These wards were identified by Chief Nurses at each of the participating Trusts. Visits included facilitated discussions with ward teams, predominantly nursing staff, alongside informal engagement with staff during ward *walkarounds*. Representatives from local care homes and other stakeholders participated in the visits, providing direct opportunities for staff to discuss discharge challenges, share experiences and identify potential improvement actions.

The campaign was intentionally designed as a face-to-face intervention. Rather than focusing solely on the dissemination of information, it aimed to create opportunities for dialogue, reflection and relationship-building between hospital and care home staff.

Chapter 4. Evaluation

4.1 Methodology

The evaluation focused on staff awareness, understanding and intended changes to practice. It did not seek to measure the direct impact on discharge performance, delays or resident outcomes. The methodology combined quantitative feedback collected through a feedback form with qualitative analysis of free-text responses and verbal feedback gathered during ward visits. Feedback forms were distributed to staff following each ward visit. Not all respondents completed every question and therefore denominators vary throughout the analysis.

4.2 Feedback received

A total of 66 staff members completed the feedback form following participation in a ward visit. Responses were received from all four participating Trusts, with the largest number of responses from King's College Hospital NHS Foundation Trust (24 responses), followed by Lewisham and Greenwich NHS Trust (19), Oxleas NHS Foundation Trust (18) and Guy's and St Thomas' NHS Foundation Trust (5).

Of the 63 participants who answered the question relating to their role, **43 (68%) were directly involved in discharging patients to care homes**, demonstrating that the majority of respondents were staff with direct experience of hospital to care home discharge processes.

Overall, **97% of respondents reported learning either "a lot" or "a little" about care homes or working with care homes as a result of the campaign**, indicating that the intervention was successful in increasing awareness and understanding amongst participants.

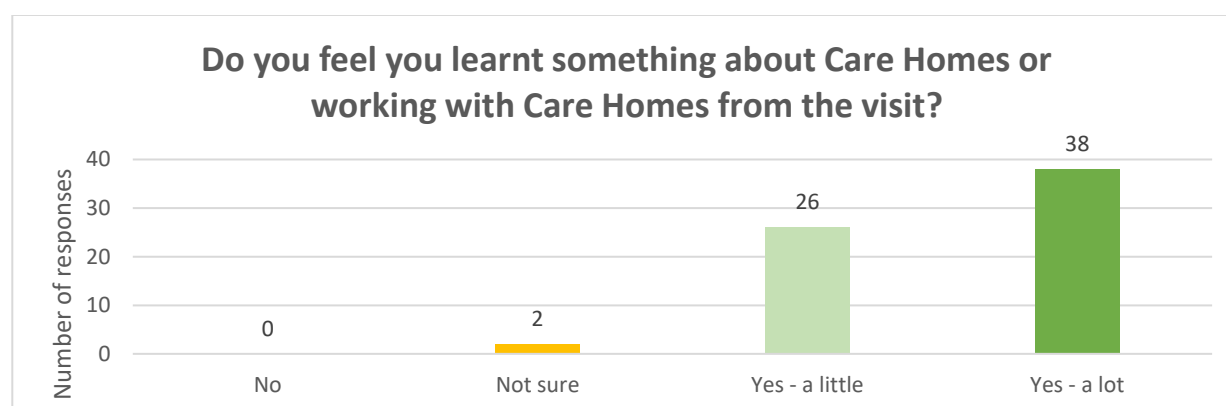


Figure 2. Responses provided to feedback form completed during ward visits.

Feedback demonstrated increased awareness across the campaign's key messages. While many participants already felt confident in some areas of discharge practice, particularly the need to provide medication, equipment and discharge summaries, the feedback showed that across the core themes, the campaign helped build on existing knowledge and understanding.

Statement	I already knew this and feel confident about it	I already knew this, but this visit improved my understanding	I am still unsure about this	This was new information for me
1. Care home nurses may be the only registered practitioner on site at a care home.	37%	31%	3%	29%
2. Clinical information on care home residents should be shared with care home staff in the same way as other MDT members	51%	35%	3%	11%
3. Patients should be discharged to care homes with all required equipment, medication and supplies	74%	22%	0%	5%
4. Patients with CPE should be referred to the infection control team and health protection team before referral to a care home.	48%	29%	2%	22%
5. Care home nurses need a clear, complete discharge summary before the patient leaves the hospital.	70%	26%	2%	3%

Table 1. Responses provided via feedback forms completed during ward visits.

Intended Changes to Practice

Participants were asked whether the visits would influence their future practice. In total 50 comments were left to the question “*As a result of this visit, is there anything you will do differently in your practice?*” Free-text responses demonstrated a strong commitment to improving communication and collaboration with care homes. Common actions identified by respondents included:

- Communicating with care homes earlier and more regularly.
- Providing clearer and more comprehensive patient information.
- Improving discharge planning and coordination.
- Supporting care home assessment processes.
- Ensuring discharge documentation, medication and equipment are provided consistently.
- Developing a greater understanding of the care home perspective.

Communication was by far the most frequently occurring theme, with many participants highlighting the importance of keeping care homes informed throughout a resident's admission and discharge journey.

Examples of commitments made by staff:

GST staff member – “Ensure clear and accurate communication. Ensure it is timely, completed and any updates have been shared”.

KCH staff member – “Ensuring communication with nursing homes is in depth and there is someone on hand to speak to nursing home assessor”.

LGT staff member – “Communication and transparency with the care home. Giving them a true reflection of the patient especially changes with their needs and with their medication”.

Oxleas staff member – “Improve the link between our MH liaison team, home treatment team and patient flow team with care homes”.



Other feedback

The feedback form also asked for any additional comments or suggestions. 28 people provided comments and the feedback regarding the campaign was overwhelmingly positive. Participants valued the opportunity to engage directly with care home colleagues, discuss challenges and share perspectives. Several respondents described the sessions as informative and useful, whilst others highlighted the benefits of face-to-face engagement in building relationships between organisations. An example of the comments is provided below.

Example of feedback provided by nurse at KCH – “This meeting was a great opportunity for staff to meet face-to-face and share experiences”.

Suggestions for future activity included widening participation to include doctors, site managers, discharge coordinators, transport services and bed management teams, alongside continuing joint engagement between hospital and care home staff.

4.3 Summary of evaluation

The evaluation demonstrates that the campaign successfully increased awareness of key issues affecting hospital to care home discharge and strengthened mutual understanding. Participants reported increased knowledge, a willingness to change practice and strong support for closer partnership working. Communication, information sharing and collaborative working emerged consistently across both the quantitative and qualitative findings, suggesting that these remain the areas with greatest potential to improve discharge experiences for residents and staff.

In addition to feedback, information generated during ward discussions was recorded and reviewed to identify actions, improvement opportunities and issues raised by participants. These insights were considered alongside the feedback to provide a broader understanding of the campaign's impact and to inform actions and recommendations.



Chapter 5. Discussion

Themes Emerging from discussions during the ward visits

Overall, discussions during the visits were constructive and demonstrated strong support for closer partnership working between hospitals and care homes. Whilst a number of challenges were identified, there was a consistent willingness from both sectors to work collaboratively to improve discharge processes and resident outcomes. Many of the themes raised led directly to practical actions and opportunities for improvement.

1. Communication and Information Sharing

Communication was the most frequently discussed theme across the ward visits. Both hospital and care home staff highlighted challenges in obtaining accurate, timely information throughout the discharge process, particularly during assessments and at the point of discharge. Participants identified opportunities to improve communication through named ward contacts, clear escalation routes, more consistent sharing of patient information and greater use of existing communication channels. There was also recognition that multiple teams often contact care homes regarding the same resident, creating duplication and inefficiencies. Both sectors expressed a desire for simpler and more coordinated approaches to information sharing.

2. Patient Assessment Processes

Assessment processes were discussed extensively and generated a range of perspectives. Whilst some ward teams found telephone or virtual assessments useful as an initial step, care home representatives generally expressed a preference for in-person assessments. There was broad agreement that assessments work best when undertaken at agreed times and supported by effective communication between the ward and care home. Discussions also highlighted opportunities to reduce unnecessary reassessments and improve understanding of the factors that influence care home decisions. Hospital teams frequently requested more detailed feedback when a resident was not accepted by a care home, enabling them to better understand any barriers and address issues where possible.

3. Discharge Planning and Care Home Admission Times

Discussions explored the practical challenges associated with discharge timing and care home admission processes. Most care homes confirmed that they operate a 4pm cut-off for new admissions, whilst clarifying that returning residents can generally return later where required. Care homes explained that admission times are influenced by factors such as staffing arrangements, admission procedures and GP registration requirements. There was recognition that discharge delays often arise from system-wide factors rather than any single organisation, and participants expressed interest in exploring opportunities to improve planning and flexibility wherever possible.

4. Supplies, Medication and Discharge Information

The provision of medication, equipment and discharge information was another recurring theme. Hospital teams confirmed that providing at least two weeks of medication on discharge is standard practice. However, care homes reported occasions where discharge summaries, medication or other important information had



not accompanied residents on discharge. Participants agreed that timely provision of comprehensive discharge information is essential to supporting safe transitions of care and reducing avoidable issues following discharge. Hospital teams welcomed feedback from care homes where standards had not been met so that concerns could be investigated and addressed.

5. Wider System Challenges

A number of wider system issues were identified during discussions. Care homes reported difficulties accessing and making full use of digital systems such as the London Care Record and Universal Care Plan. Transport arrangements were frequently cited as a source of uncertainty, making it difficult for ward staff and care homes to predict when residents would arrive. Participants also highlighted increasing resident complexity, limited care home capacity and challenges in securing appropriate placements. These issues were recognised as broader system pressures that can contribute to discharge delays and impact both hospital and care home teams.

Overall, the discussions demonstrated that many of the challenges affecting discharge are shared across organisations and that there is significant appetite from both hospital and care home staff to work together to improve communication, strengthen relationships and identify practical solutions.



Chapter 6. Findings, actions and recommendations

The feedback received and discussions during ward visits demonstrated that the campaign strengthened understanding and encouraged constructive dialogue between hospital and care home staff. It also informed the findings, actions and recommendations shown in the table below.

What did we learn? Finding	What will we do next? Action(s)	Recommendations
1. Open and clear communication between organisations and teams enables safe, consistent and efficient discharge. Staff feedback and discussions highlighted the benefits of ward and care home staff having direct communication and escalation routes.	Support exchange of information between staff: ○ Elderly care ward key contacts. ○ Care home information (e.g. nursing / residential/ mixed, bed numbers, key specialities) and escalation contact(s).	Hospital ward and care home staff should be empowered to communicate openly and to proactively address issues.
2. Discharge works best when there is trust and understanding between system partners. One of the strongest themes emerging from the ward visits was the value of having strong relationships between care home and hospital staff.	Host a strategic discussion to explore opportunities for ward and care home nurses to gain experience across both settings, including supernumerary shifts.	Hospital ward and care home staff should continue to invest in relationship-building activity.
3. Different care homes and wards often had different processes and documentation for patient assessments leading to inefficiency. Assessment processes were identified as a common source of frustration and inefficiency.	Co-develop and share SEL principles for assessment to minimise variation and promote good practice.	Hospital ward and care home staff should routinely communicate the most important operational requirements in the assessment process e.g. sharing preferred assessment timeslots.
4. Care home staff do not always have access to discharge information recorded in digital patient records. Staff from several care homes identified issues accessing digital systems including Universal Care Plan (UCP) and London Care Record (LCR).	Identify the barriers to adoption of LCR and UCP (high-level only). Then engage with London and ICB digital leads to understand available support and strategic plans for care homes.	Care homes, digital leads and system partners should support access to digital patient information and systems wherever possible, informed by patient need.
5. There is value in cascading learning from the campaign with all those involved in discharging patients from hospitals to care homes. Campaign messages would be beneficial for medical staff, bed managers, site managers, discharge coordinators, transport, therapy teams, community services and social services.	Explore development of a resource designed to provide hospital staff with an understanding of the realities of working in a care home.	Hospital leads should share key messages from the campaign with other staff groups and hospital departments.

In addition to the actions above, this report will be shared with Trusts, care homes and other system partners. **All system partners** are asked to share this report with relevant colleagues.



Chapter 7. Conclusion

The feedback demonstrates that a targeted awareness and engagement campaign can make a meaningful contribution to improving understanding, communication and partnership working between hospital and care home staff across South East London. The campaign successfully increased awareness of the key messages, with 97% of participants reporting that they had learnt something about care homes or working with care homes as a result of the visits. Participants also reported increased understanding of issues relating to information sharing, care home nursing, discharge planning and infection prevention, alongside a willingness to adapt their own practice to support safer and more effective discharge processes.

The campaign's impact extended beyond awareness raising. Feedback and discussions during the visits demonstrated strong support for closer partnership working between hospitals and care homes. Communication, information sharing and collaborative working emerged consistently as the themes most likely to influence discharge experiences and outcomes. The in-person visits provided valuable opportunities for staff to share perspectives, challenge misconceptions and develop a greater understanding of the operational realities faced by colleagues working in different sectors. In addition, conversations generated practical actions and identified opportunities for improvement that can be taken forward at local and system level.

Whilst this report does not directly assess the impact of the campaign on discharge performance or system outcomes, feedback shows that the visits strengthened the foundations required for improvement. Furthermore, staff demonstrated a readiness to improve communication, engage earlier in discharge planning and adopt more collaborative approaches to supporting residents moving between care settings. Continued partnership working, implementation of the recommendations and ongoing engagement between hospital and care home staff can provide an opportunity to build on this learning. This will contribute to the wider South East London ambition of delivering safe, effective and person-centred care through more integrated working across health and social care.

The campaign has demonstrated that relatively low-cost engagement activity can generate meaningful learning, improve relationships and identify practical system improvements. These findings suggest that further investment in joint learning and improvement activity between hospitals and care homes could support South East London's wider ambitions for integrated, person-centred care.



Chapter 8. Acknowledgements

Thanks go to all of the organisations and staff involved in the project – from initiation of ideas, campaign development, ward visits and evaluation.

The project activity was guided and informed by the SEL ICS Social Care Reference Group:

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2	Benny Okpor	Social Care Nursing Clinical Practice Development Lead	South East London Integrated Care System	Project delivery lead
3	Lizzie Wallman	Deputy Chief Nurse	South East London Integrated Care System	Nurse and Quality Leadership ICB Leadership / Champion
4	Raph Broughton	Workforce Transformation Lead	South East London Integrated Care System	Strategic Project Lead – Alternate is Rebekah Middleton
5	Margaret Sharpe/ Laura Anthony	Locality Manager - (London and South East)	Skills for Care	Skills for Care (National organisation delivering support for Adult Social Care Sector)
6	Kehinde Ogunsola	Care Homes Quality Liaison Nurse	South East London Integrated Care System	Borough Care Home or Quality Lead
7	Sara Quirke	Joint Care Home Programme Lead	Bromley	
8	Khadija Kachra Maribel Madrid Pascual	Home Manager Home Manager	Bromley Marlborough Court Care Home	Care Home Representative – Clinical
9	Sue Robinson	Assistant Director of System Integration and Development	Lewisham Transfer of Care Hub in Partnership with London Borough of Lewisham	Transfer of Care Lead & Discharge Solutions Group Member
10	Laura Williams	Head of Integrated Commissioning for Older People	London Borough of Bexley & SEL ICS	Commissioner for Older People Care Homes

The artificial intelligence platform, Microsoft copilot, has been used to support the write up of some elements of this report.



Chapter 9. References

The references listed below include the national policy documents, regional strategies, internal project documentation and evaluation datasets which informed the design, delivery and evaluation of the Hospital to Care Home Discharge Improvement Campaign and wider project.

1. Department of Health and Social Care. Fit for the Future: The 10 Year Health Plan for England. London: DHSC; 2025. www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future
2. NHS England. Enhanced Health in Care Homes (EHCH) Framework. NHS England. Available at: <https://www.england.nhs.uk/long-read/enhanced-health-in-care-homes-framework>. Accessed August 2026.
3. NHS England. The NHS Long Term Plan. NHS England; 2019. Available at: <https://www.longtermplan.nhs.uk>. Accessed August 2026.
4. NHS England. Neighbourhood Health Service and Neighbourhood Health Guidelines. NHS England; 2025. www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/
5. Department of Health and Social Care. Hospital Discharge and Community Support Guidance. London: DHSC. Latest available version. www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance
6. Department of Health and Social Care. Better Care Fund Policy Framework and Planning Requirements 2025-26. London: DHSC; 2025. www.gov.uk/government/publications/better-care-fund-policy-framework-2025-to-2026/better-care-fund-policy-framework-2025-to-2026
7. OneLondon. Universal Care Plan (UCP). Available at: <https://ucp.onelondon.online>. Accessed August 2026.
8. OneLondon. London Care Record. Available at: <https://www.onelondon.online/london-care-record>. Accessed August 2026.



Appendices

Appendix 1. Glossary

Term	Full Term	Definition
BCF	Better Care Fund	A pooled budget between the NHS and local authorities that supports integrated health and social care services, including discharge improvement and admission avoidance initiatives.
CPE	Carbapenemase-Producing Enterobacterales	A group of antibiotic-resistant bacteria which require specific infection prevention and control measures when transferring patients between care settings.
CHC	Continuing Healthcare	A package of care funded solely by the NHS for individuals with significant ongoing healthcare needs.
EHCH	Enhanced Health in Care Homes	A national NHS framework that supports collaborative working between care homes, primary care, community services and other partners to improve health outcomes for care home residents.
GP	General Practitioner	A doctor working in primary care who provides medical care and coordinates many aspects of a patient's healthcare.
HCA	Healthcare Assistant	A member of the healthcare workforce who supports clinical staff in delivering patient care.
ICB	Integrated Care Board	The statutory NHS organisation responsible for planning and funding healthcare services within an Integrated Care System.
ICS	Integrated Care System	A partnership of NHS organisations, local authorities, social care providers and other stakeholders working together to improve health and care outcomes for a local population.
LCR	London Care Record	A shared digital care record that enables authorised health and care professionals to access relevant patient information across organisational boundaries.
LAS	London Ambulance Service	The NHS ambulance service responsible for providing emergency and urgent care services across London.
LTC	Long-Term Condition	A health condition that cannot currently be cured but can be managed through treatment and ongoing care. Examples include diabetes, chronic obstructive pulmonary disease and heart failure.
MDT	Multidisciplinary Team	A group of professionals from different disciplines who work together to assess needs, plan care and make decisions about a patient's treatment and support.
NHS	National Health Service	The publicly funded healthcare system in England.
NHSE	NHS England	The national body responsible for overseeing the delivery and performance of NHS services in England.
Pathway 3	Discharge Pathway 3	A discharge pathway for individuals who require a short-term bed-based setting before returning home or moving to longer-term care. This often includes residential and nursing care placements.
PEoLC	Palliative and End of Life Care	Care that focuses on quality of life, symptom management and support for people with life-limiting illness and those important to them.
SEL	South East London	The geographical area comprising the London boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark.
SEL ICS	South East London Integrated Care System	The partnership of NHS organisations, local authorities and other stakeholders responsible for planning and delivering health and care services across South East London.
ToC	Transfer of Care	The movement of a patient between care settings, including discharge from hospital to a care home.



UCP	Universal Care Plan	A London-wide digital care planning platform that enables health and care professionals to access and share personalised care plans.
VCSE	Voluntary, Community and Social Enterprise	Organisations operating within the voluntary and community sector that often provide care, support and advocacy services.

Other terms used in this report

Term	Definition
Hospital to Care Home Discharge Improvement Campaign	A South East London awareness and engagement campaign designed to improve understanding, communication and partnership working between hospitals and care homes.
Discovery Phase	The initial phase of the project involving stakeholder engagement, data analysis and identification of priorities to inform campaign design.
Hospital to Care Home Discharge	The process whereby a patient is discharged from hospital and returns to, or is admitted to, a residential or nursing care home.
Key Messages	A series of co-produced messages used during ward visits to improve awareness and understanding of discharge-related issues.
Parity	The principle that health and social care professionals should be recognised and treated as equal partners in supporting residents and patients.
Trusted Assessor	A practitioner who undertakes assessments on behalf of multiple providers to support efficient discharge and placement decisions.

Appendix 2. Feedback form





South East London

Care Home Discharge Campaign - Visit feedback form

Please answer the questions below. Alternatively, you can provide feedback online using the QR code.



This will help us understand if the visit has been helpful to you and will inform our evaluation of the campaign.

1. Which Trust do you work in?
☐ Guys and St Thomas' ☐ Kings College Hospital ☐ Lewisham and Greenwich ☐ Oxleas

2. Do you feel you learnt something about Care Homes, or working with Care Homes from the visit?
☐ No ☐ Not sure ☐ Yes – a little ☐ Yes – a lot

3. Please read the following statements, and then for each statement indicate which option best applies for you. Please think about your knowledge before and after the visit when answering.

Please tick the appropriate box for each of the statements below	I already knew this and feel confident about it	I already knew this, but this visit improved my understanding	This was new information for me	I am still unsure about this
Care home nurses may be the only registered practitioner on site at a care home.				
Clinical information on care home residents should be shared with care home staff in the same way as other members of the MDT.				
Patients should be discharged to care homes with all required equipment, medication, and supplies.				
Patients with CPE should be referred to the infection control team and health protection team before referral to a care home.				
Care home nurses need a clear, complete discharge summary before the patient leaves the hospital.				

4. As part of your current role, are you directly involved in discharging patients to care homes?
☐ No ☐ Yes ☐ Not sure

Please turn over to complete feedback survey

5. As a result of this visit, is there anything you will do differently in your practice? If yes, please describe?

6. Any additional comments or suggestions?

Many thanks for completing this survey. If you have any questions or would like to discuss further, please get in touch via email - gstt.selicsworkforce@nhs.net.

Appendix 3. List of care homes joining visits

Borough	Care Home
Bexley	Marlborough Court
Bromley	- Homefield - Kyn - Willett
Greenwich	- Time Court - Brook House - The Oaks
Lambeth	British Homes
Lewisham	Alexandra Care Home
Southwark	- Waterside - Tower Bridge - Greenhive Care Home



Appendix 4. Ward visit schedule

Trust	Hospital	Ward	Care home(s) on visit	Stakeholders	Trust leads	Date
GST	St Thomas'	Alexandra, Anne and Henry Wards	- Waterside, Southwark - Tower Bridge, Southwark - Greenhive care home, Southwark	Integrated Commissioning Manager - Age Well, Southwark Council and South East London ICB	Head of Nursing and Matron	2 nd July
	Lewisham	Aspen and Oak Ward	None	- Clinical Lead (Palliative and End of Life Care), SEL ICS - Lead Quality Assurance Officer for RBG Older People Care Homes, Greenwich - Care Home Liaison (TOCH), Lewisham.	Senior Matron and Matron	18 th June
LGT	Lewisham	Mulberry and Hawthorn wards	- Alexandra Care Home, Lewisham - Time court Greenwich - Brook House Greenwich - The Oaks Greenwich - Time court Greenwich - Willett CH, Bromley - Homefield CH, Bromley - Marborough Court, Bexley	- Associate Director, Physical Disability, Lewisham. - Care Home Trusted Assessor, Bexley - Head of Integrated Commissioning for Older People, Bexley	- Matron - Senior Discharge Coordinator - Senior Nurse Complex Discharge advisor.	16 th June
	QEH	Ward 14 A and B, ward 18 and 19.	None	Clinical Lead (Palliative and End of Life Care), SEL ICS	- Greenwich Integrated Flow Lead, Transfer of Care Hub - Ward Matrons.	30 th June
	QEH	Ward 2, 20 and 22	None	Clinical Lead (Palliative and End of Life Care), SEL ICS	- Matron - Matrons - Transfer of Care Lead, Complex Discharge Team - Lead Nurse, Acute specialty medicine. - Chief Nurse, KCH. - Head of nursing - Matrons - Discharge Manager - Transfer of Care Lead. - Head of Nursing - Matrons - Older Peoples Lead for Acute and Crisis Services, Oxleas.	30 th July
	Denmark Hill Wards	Marjory Warren, Donne and Byron Wards	British Homes, Lambeth	Clinical Lead (Palliative and End of Life Care), SEL ICS.	- Transfer of Care Lead, Complex Discharge Team - Lead Nurse, Acute specialty medicine. - Chief Nurse, KCH. - Head of nursing - Matrons - Discharge Manager - Transfer of Care Lead. - Head of Nursing - Matrons - Older Peoples Lead for Acute and Crisis Services, Oxleas.	16 th June
KCH	PRUH	D1, M1 and M2	- The Oaks Greenwich - Kyn Bromley		- Head of Nursing, Acute & Crisis - Older Peoples Lead for Acute and Crisis Services, Oxleas. - Consultant Psychiatrist - Older Peoples Lead for Acute and Crisis Services, Oxleas. - Older Peoples Lead for Acute and Crisis Services, Oxleas.	22 nd June
	Orpington	Churchill, Elizabeth and Quebec.	- The Oaks Greenwich - Kyn Bromley	Care Home Trusted Assessor, Bexley	- Head of Nursing, Acute & Crisis - Older Peoples Lead for Acute and Crisis Services, Oxleas.	22 nd June
Oxleas	Queen Mary's	Holbrook Ward in Woodlands	The Oaks Greenwich		- Head of Nursing, Acute & Crisis - Older Peoples Lead for Acute and Crisis Services, Oxleas. - Consultant Psychiatrist - Older Peoples Lead for Acute and Crisis Services, Oxleas. - Older Peoples Lead for Acute and Crisis Services, Oxleas.	23 rd June
	PRUH	Scadbury Ward in Green Parks House	- The Oaks Greenwich - Kyn Bromley		- Head of Nursing, Acute & Crisis - Older Peoples Lead for Acute and Crisis Services, Oxleas. - Consultant Psychiatrist - Older Peoples Lead for Acute and Crisis Services, Oxleas. - Older Peoples Lead for Acute and Crisis Services, Oxleas.	22 nd June
	Memorial	Oaktree Lodge		Infection Prevention & Control Nurse (Social Care)	- Head of Nursing, Acute & Crisis - Older Peoples Lead for Acute and Crisis Services, Oxleas.	24 th June
	QEH	Shepherdless Ward		Infection Prevention & Control Nurse (Social Care)	- Head of Nursing, Acute & Crisis - Older Peoples Lead for Acute and Crisis Services, Oxleas.	24 th June



Appendix 5. Hospital to Care Home Improvement Campaign – further information

Identifying key messages

Through engagement and completion of the discovery phase, an extensive list of messages were identified which covered a range of topics relating to discharge and the interface between care homes and hospitals. These were then sorted into themes and prioritised based on urgency and impact. These messages focused on areas identified as having the greatest impact on discharge quality and resident experience, including communication, information sharing, discharge documentation, infection prevention and understanding the care home environment.

The drafted key messages were then shared with a designer, who then worked with the project team to create a campaign logo and a range of merchandise to be shared with hospital staff. The project team focused conversation on these messages during visits.

Evaluation

Feedback forms were shared during all visits to staff working across Guy's and St Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust, Lewisham and Greenwich NHS Trust and Oxleas NHS Foundation Trust. The feedback form included a combination of closed and open-ended questions designed to explore learning from the visits, understanding of key campaign messages and intended changes to practice. The feedback form also provided an opportunity for participants to offer suggestions for future improvement and further collaboration.

Quantitative data were analysed, with a focus on the extent to which staff reported learning from the campaign and their understanding of the key messages shared during the visits. Findings were used to identify which campaign messages generated the greatest awareness and to assess the overall reach and impact of the intervention.

Qualitative data from free-text responses were analysed using thematic analysis. Responses were reviewed and coded to identify common themes, patterns and areas of learning. Attention was given to understanding how participants intended to change their practice following the visits, what aspects of the campaign they found most valuable and what additional improvements they felt would support better discharge processes. Representative quotations are presented to illustrate key themes and findings.

Limitations

Several limitations should be considered when interpreting the findings of the report. Completion of the feedback forms was voluntary, and responses reflect staff perceptions rather than direct measures of discharge outcomes. The feedback was collected immediately following the ward visits and therefore assesses changes in awareness, understanding and intended practice rather than longer-term behavioural change or impacts on discharge performance. Despite these limitations, the combination of quantitative and qualitative findings provides a useful assessment of the campaign's contribution to improving understanding, communication and partnership working between hospital and care home staff.



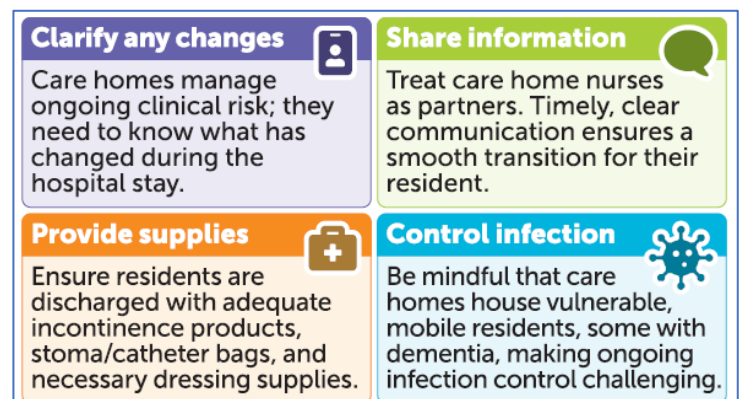
Examples of campaign merchandise

The campaign posters can be downloaded from the SEL ICS website - www.selondonics.org/icb/healthcare-professionals/working-in-partnership-with-care-homes. Examples of the campaign merchandise are shown below.

Campaign logo



Lanyard Card



Z-card handout

