NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Transition between inpatient mental health settings and community or care home settings

Output: Prioritised quality improvement areas for development.

Date of quality standards advisory committee meeting: 5 January 2017

Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for transition between inpatient mental health settings and community or care home settings. It provides the committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the committee in considering potential statements and measures.

1.2 Development source

The key development source referenced in this briefing paper is:

Transition between inpatient mental health settings and community or care home settings. NICE guideline 53 (2016).

[Next review due August 2018]

2 Overview

2.1 Focus of quality standard

This quality standard will cover the period before, during and after a person is admitted to, and discharged from, a mental health hospital. It will include children, young people and adults who are admitted from, or discharged to, care homes and other community settings.

2.2 Background

Poor transition between inpatient mental health settings and community or care home settings has negative effects on people using services and their families and carers. A key issue affecting transitions between inpatient mental health settings and the community is a lack of integrated and collaborative working between mental health and social care services, and between practitioners based in hospitals and those in the community. Both can result in inadequate and fragmented support for people using mental health services.

People who use inpatient mental health services and their families and carers have reported a number of problem areas:

- delayed assessment and admission, so that the person is not treated until they are in crisis
- inadequate planning for – and support after – discharge, resulting in readmissions
- the person and their family or carers not being involved in planning admission, treatment and discharge
- people being discharged having no help to manage the mental health symptoms and other problems that contributed to their admission
- failure to give people the information, advocacy and support they need
- failure to arrange support to help the person reintegrate into the life they want to lead in the community (for example, returning to employment, education and social activities).

Older people are sometimes discharged to care homes when they might have been able to return to their own homes if extra support, such as home care, had been arranged in advance.

The impact of poor discharge planning on young people who are not supported to reintegrate into education and training can have long-lasting consequences for their life chances.

People placed in inpatient facilities away from their home communities are particularly vulnerable to delayed discharges, because case management is difficult at a distance. Delayed discharge is an unnecessary expense to the NHS, but also has consequences for patients, who may become dependent on inpatient care, lose coping skills that they will need after discharge, and find that personal relationships are damaged, and housing or jobs lost.

2.3 Statistics

NHS Digital's Mental Health Bulletin: 2015-16 Annual Report estimated that there were 126,870 admissions and 122,262 discharges across adult secondary mental health and learning disabilities services in England.

The consequences of a poor transition can be very serious for the person and their family or carers. For example, the University of Manchester's National Confidential Inquiry into Suicide and Homicide by People with Mental Illness found that, between 2004 and 2014 in England, 2,305 mental health patients died by suicide in the first 3

months after being discharged from hospital (compared with 1,207 inpatient deaths in the same period).

2.4 National outcome frameworks

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** ***Outcome measures*** **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 **Carers can balance their caring roles and maintain their desired quality of life** 1D Carer-reported quality of life** **People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation** 1I Proportion of people who use services and their carers, who reported that they had as much social contact as they would like
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
1 Preventing people from dying prematurely	***Improvement areas***

	Reducing premature mortality in people with mental illness 1.5 i Excess under 75 mortality rate in adults with serious mental illness* *ii Excess under 75 mortality rate in adults with common mental illness** *iii Suicide and mortality from injury of undetermined intent among people with recent contact from NHS services***
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*** **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition **Enhancing quality of life for people with mental illness** 2.5 i Employment of people with mental illness** *ii Health-related quality of life for people with mental illness*** **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*.***
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*** **Improving outcomes from planned treatments** 3.1 Total health gain as assessed by patients for elective procedures *ii Psychological therapies* *iii Recovery in quality of life for patients with mental illness* **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*** 4b Patient experience of hospital care 4c *Friends and family test* *4d Patient experience characterised as poor or worse* *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 experience of healthcare for people with mental illness** *4.7 Patient experience of community mental health services* **Improving children and young people's experience of healthcare** *4.8 Children and young people's experience of inpatient services* **Improving people's experience of integrated care** *4.9 People's experience of integrated care***
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, 2016–2019

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors which affect health and wellbeing and health inequalities ***Indicators*** 1.06 Adults with a learning disability/in contact with secondary mental health services who live in stable and appropriate accommodation** 1.08 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services*, **
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*** 4.09 Excess under 75 mortality rate in adults with serious mental illness* 4.10 Suicide rate** 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 ** Indicator is complementary	

3 Summary of suggestions

3.1 Responses

In total 15 stakeholders responded to the 2-week engagement exercise 4/11/16-18/11/16.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 4 for further consideration by the committee.

NHS Improvement's patient safety division submitted comments during stakeholder engagement, which are summarised in this paper and can be found in full in appendix 2.

Full details of all the suggestions provided are given in appendices 3 and 4 for information.

Table 4 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Hospital admission • Planning for hospital admission • On admission • Out-of-area admissions	PUK, RCGP, SCM1, SCM2, SCM3, SCM4, Mind
Hospital discharge • Discharge planning • Psychoeducation • Communication on discharge	RCGP, RCPsych, SCM1, SCM3, SCM4, NCD, Mind, NHSI
Follow-up support • Named coordinator • Timing of follow-up • Continuing therapy	RCPsych, SCM1, SCM2, SCM4, NCD
Support for families, parents and carers • Sharing information with families, parents and carers • Carers' assessments	PUK, SCM1, SCM3
Additional areas • National database of community mental health teams • Addressing the needs of black and minority ethnic groups	RCGP, Mind

PUK, Parkinsons UK
RCGP, Royal College of General Practitioners
NCD, National Clinical Director for Mental Health for NHS England
RCPsych, Royal College of Psychiatrists (Faculty of Old Age Psychiatry)
Mind, the mental health charity
NHSI, NHS Improvement

3.2 Identification of current practice evidence

Bibliographic databases were searched to identify examples of current practice in UK health and social care settings; 812 papers were identified for transition between inpatient mental health settings and community or care home settings. In addition, 22 papers were suggested by stakeholders at topic engagement and 4 papers internally at project scoping.

Of these papers, 3 have been included in this report and are included in the current practice sections where relevant. Appendix 1 outlines the search process.

4 Suggested improvement areas

4.1 Hospital admission

4.1.1 Summary of suggestions

Planning for hospital admission

Stakeholders highlighted that all teams involved in a person's care should be kept informed and be in communication with each other throughout hospital admissions. This may include social care teams, mental health community services and teams at a geographical distance, for example if a young person is away from home at university. A stakeholder highlighted that more time and specialist input may need to be provided for people with complex needs, such as those with Parkinson's disease to make their transitions more successful.

On admission

Stakeholders highlighted that people who are admitted to hospital should be given information about the ward to help them feel less anxious, vulnerable or confused. Building therapeutic relationships as early as possible can also help to give people a positive experience of admission. It was highlighted that people should be offered access to advocacy services, which may include referral to Independent Mental Health Advocates. One stakeholder highlighted that a senior healthcare professional should discuss all medication needs at admission.

Out-of-area admissions

Stakeholders highlighted that placing people outside of their home area causes a fragmentation of care and leads to poorer outcomes. They suggested where out-of-area admissions occur, named practitioners from the person's home area and the ward should work together to ensure the placement lasts no longer than required. It was suggested that specialist Child and Adolescent Mental Health provision should be available within a 50 mile radius of a young person's home to prevent them being placed far away from their home.

4.1.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 5 to help inform the committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Planning for hospital admission	**Planning and assessment** NICE NG53 recommendations 1.2.4 and 1.2.8
On admission	**General principles** NICE NG53 recommendation 1.3.1 and 1.3.4 **Addressing personal concerns** NICE NG53 recommendations 1.3.18 and 1.3.19 **Hospital care** NICE CG136 recommendations 1.6.2 and 1.6.5 **Medicines optimisation quality standard** NICE QS120 statement 4
Out-of-area admissions	**Out-of-area admissions** NICE NG53 recommendations 1.3.10 and 1.3.11

Planning and assessment

NICE NG53 recommendation 1.2.4

Allow more time and expert input to support people with complex, multiple or specific support needs to make transitions to and from services, if necessary. This may include:

- children and young people
- people with dementia, cognitive or sensory impairment
- people on the autistic spectrum
- people with learning disabilities and other additional needs
- people placed outside the area in which they live.

NICE NG53 recommendation 1.2.8

If more than 1 team is involved in a person's transition to, within and from a service, ensure there is ongoing communication between the inpatient team and other relevant teams that include:

- community health or social care providers, such as:
- the community mental health team
- the learning disability team
- teams that work with older people
- child and adolescent mental health services (CAMHS)
- housing support teams
- general hospital or psychiatric liaison teams.

General principles

NICE NG53 recommendation 1.3.1

Start building therapeutic relationships as early as possible to:

- lessen the person's sense of being coerced
- encourage the person to engage with treatment and recovery programmes and collaborative decision-making
- create a safe, contained environment
- reduce the risk of suicide, which is high during the first 7 days after admission.

This is particularly important for people who have been admitted in crisis.

NICE NG53 recommendation 1.3.4

At admission, offer all people access to advocacy services that take into account their:

- language and communication needs
- cultural and social needs
- protected characteristics (see the GOV.UK page about discrimination).

Addressing personal concerns

NICE NG53 recommendation 1.3.18

Give the person verbal and written information about ward facilities and routines (see the section on hospital care in NICE's guideline on service user experience in adult mental health).

NICE NG53 recommendation 1.3.19

At admission, a senior healthcare professional should discuss all medication and care needs with the person being admitted. This should include:

- physical healthcare needs
- pregnancy, breastfeeding or the need for emergency contraception
- advice about immediate addiction issues, treatment and support
- mental health treatment.

Hospital care

NICE CG136 recommendation 1.6.2

Give verbal and written information to service users, and their families or carers where agreed by the service user, about:

- the hospital and the ward in which the service user will stay
- treatments, activities and services available
- expected contact from health and social care professionals
- rules of the ward (including substance misuse policy)
- service users' rights, responsibilities and freedom to move around the ward and outside
- meal times
- visiting arrangements.

NICE CG136 recommendation 1.6.5

Shortly after service users arrive in hospital, show them around the ward and introduce them to the health and social care team as soon as possible and within the first 12 hours if the admission is at night. If possible, this should include the named healthcare professional who will be involved throughout the person's stay.

Medicines optimisation quality standard

NICE QS120 statement 4

People who are inpatients in an acute setting have a reconciled list of their medicines within 24 hours of admission.

Out-of-area admissions

NICE NG53 recommendation 1.3.10

If the person is being admitted outside the area in which they live, identify:

- a named practitioner from the person's home area who has been supporting the person
- a named practitioner from the ward they are being admitted to.

NICE NG53 recommendation 1.3.11

The named practitioners from the person's home area and the ward should work together to ensure that the person's current placement lasts no longer than required. This should include reviewing the person's care plan, current placement, recovery goals and discharge plan at least every 3 months, or more frequently according to the person's needs. This could be done in person or by audio or videoconference.

4.1.3 Current UK practice

Planning for admission

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

On admission

The Care Quality Commission (CQC) produces an annual report on the use of the Mental Health Act in England. In their report, Monitoring the Mental Health Act in 2015/16, for people under the Mental Health Act, there was no evidence in 12% (515 out of 4344) of cases that people were informed of their right to an Independent Mental Health Advocate.

No published studies on current practice were highlighted about information on admission or therapeutic relationships.

Out-of-area admissions

NHS Digital began data collection on out of area placements on 17th October 2016 to monitor progress on the Government's national ambition to eliminate inappropriate out of area placements in mental health services for adults in acute inpatient care by 2020-21. Provisional data on Out of Area Placements in Mental Health Services

(October 2016) showed that there were 191 inappropriate out-of-area admissions due to unavailability of a local bed across England that started on or after 17th October and were active at the end of October 2016.

There was no additional current practice information identified about reducing out-of-area admissions.

4.1.4 Resource impact assessment

This area was not included in the resource impact assessment for NG53. It was not identified as an area that would have a significant resource impact (>£1m in England each year). This is because commissioners and providers of mental health services should work with primary care, local authorities and third sector organisations to ensure that people with mental health problems in transition have equal access to services.

4.2 Hospital discharge

4.2.1 Summary of suggestions

Discharge planning

Stakeholders highlighted the importance of discharge planning to ensure arrangements for care to be delivered are made. Discharge planning should start early, involve people fully, include community workers who are already involved with the person in hospital, and should address living arrangements and other practical concerns. It was highlighted that planning should be focussed on recovery.

Psychoeducation

It was highlighted that psychoeducation should be offered to people with psychotic illnesses and considered for people with other diagnoses to promote learning and awareness and reduce the risk of readmission.

Communication on discharge

The risk of safety incidents due to poor communication at discharge was highlighted. A lack of adequate and timely communication of information and a failure to act on information that is transferred can lead to harm for patients as well as avoidable readmissions.

Stakeholders highlighted that GPs and community psychiatric nurses should be provided with information from the discharging hospital about the person's ongoing treatment plans and medication to ensure they receive the agreed follow-up care. A stakeholder suggested that developing an online patient record while someone is in hospital would make transfer easier, and that a standard transfer form should be developed for this purpose.

4.2.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 6 to help inform the committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Discharge planning	**Hospital discharge** NICE NG53 recommendation 1.5.1 **Service user experience in adult mental health services quality standard** NICE QS14 statement 3 **Accommodation** NICE NG53 recommendation 1.5.7 **Preparing for discharge** NICE NG54 recommendation 1.5.21
Psychoeducation	**Helping the person to prepare for discharge** NICE NG53 recommendation 1.5.9
Communication on discharge	**Care planning to support discharge** NICE NG53 recommendation 1.5.20 **Follow-up support** NICE NG53 recommendation 1.6.3

Hospital discharge

NICE NG53 recommendation 1.5.1

Health and social care practitioners in the hospital and community should plan discharge with the person and their family, carers or advocate. They should ensure that it is collaborative, person-centred and suitably-paced, so the person does not feel their discharge is sudden or premature. For more information, see NICE's guideline on service user experience in adult mental health services.

Service user experience in adult mental health services

NICE QS14 statement 3

People using mental health services are actively involved in shared decision-making and supported in self-management.

Accommodation

NICE NG53 recommendation 1.5.7

Before discharging people with mental health needs, discuss their housing arrangements to ensure they are suitable for them and plan accommodation accordingly. This should take into account any specific accommodation and observation requirements associated with risk of suicide.

Preparing for discharge

NICE NG53 recommendation 1.5.21

Mental health practitioners should carry out a thorough assessment of the person's personal, social, safety and practical needs to support discharge. The assessment should include risk of suicide (see recommendations 1.6.6–1.6.8). It should:

- relate directly to the setting the person is being discharged to
- fully involve the person
- be shared with carers (if the person agrees)
- explore the possibility of using a personal health or social care budget and ensure the person understands about charges for social care
- cover aftercare support, in line with section 117 of the Mental Health Act 1983
- cover aspects of the person's life including:
    - daytime activities such as employment, education and leisure
    - food, transport, budgeting and benefits
    - pre-existing family and social issues and stressors that may have triggered the person's admission
    - ways in which the person can manage their own condition
    - suitability of accommodation.

Helping the person to prepare for discharge

NICE NG53 recommendation 1.5.9

Before discharge, offer a series of individualised psychoeducation sessions for people with psychotic illnesses to promote learning and awareness. Sessions should:

- start while the person is in hospital
- continue after discharge so the person can test new approaches in the community
- cover:
    - symptoms and their causes

    - what might cause the person to relapse, and how that can be prevented
    - psychological treatment
    - coping strategies to help the person if they become distressed
    - risk factors
    - how the person can be helped to look after themselves
- be conducted by the same practitioner throughout if possible.

Care planning to support discharge

NICE NG53 recommendation 1.5.20

Send a copy of the care plan to everyone involved in providing support to the person at discharge and afterwards. It should include:

- …
- details of medication (see the recommendations on medicines-related communication systems in NICE's guideline on medicines optimisation)
- details of treatment and support plan
- physical health needs including health promotion and information about contraception
- date of review of the care plan.

Follow-up support

NICE NG53 recommendation 1.6.3

At discharge, the hospital psychiatrist should ensure that:

- Within 24 hours, a discharge letter is emailed to the person's GP. A copy should be given to the person and, if appropriate, the community team and other specialist services.
- Within 24 hours, a copy of the person's latest care plan is sent to everyone involved in their care (see recommendation 1.5.20).
- Within a week, a discharge summary is sent to the GP and others involved in developing the care plan, subject to the person's agreement. This should

include information about why the person was admitted and how their condition has changed during the hospital stay.

4.2.3 Current UK practice

Discharge planning

The CQC report, 'Monitoring the Mental Health Act 2015-16' showed that 32% (1324 out of 4086) of care plans they reviewed during 2015/16 (for people under the Mental Health Act) showed no evidence of discharge planning. This is a slightly larger proportion than the 29% in 2014/15. It also showed that there was no evidence of patient involvement or patient views in 29% (1,214) of the care plans that were reviewed.

No published studies on current practice were highlighted on the timing of discharge planning or involvement of community workers.

Psychoeducation

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Communication on discharge

Communication at handover accounted for approximately 33% of the 10,000 patient safety incidents that were reported to the National Reporting and Learning System between October 2012 and September 2013. Approximately 150 of the incidents related to people discharged from mental health acute care (see appendix 2).

4.2.4 Resource impact assessment

This area was not included in the resource impact assessment for NG53. It was not identified as an area that would have a significant resource impact (>£1m in England each year).

4.3 Follow-up support

4.3.1 Summary of suggestions

Named coordinator

It was highlighted that giving all people who are discharged from hospital a named care coordinator or single point of contact to support discharge helps them to access services and support and reduce the risk of readmission.

Timing of follow-up

Stakeholders emphasised that the period after discharge is a period of high risk of suicide and that people should be followed up within 7 days or within 48 hours if a risk of suicide has been identified.

Continuing therapies

It was suggested that talking therapies that have been started while the person is in hospital should continue once they are discharged.

4.3.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 7 to help inform the committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Named coordinator	**Care planning to support discharge** NICE NG53 recommendation 1.5.15 **Follow-up support** NICE NG53 recommendation 1.6.1
Timing of follow-up	**Follow-up support** NICE NG53 recommendations 1.6.7 and 1.6.8
Continuing therapies	Not directly covered in NICE NG53 and no recommendations are presented

Care planning to support discharge

NICE NG53 recommendation 1.5.15

Ensure that there is a designated person responsible for writing the care plan in collaboration with the person being discharged (and their carers if the person agrees).

Follow-up support

NICE NG53 recommendation 1.6.1

Discuss follow-up support with the person before discharge. Arrange support according to their mental and physical health needs. This could include:

- contact details, for example of:
    - a community psychiatric nurse or social worker
    - the out-of-hours service
- support and plans for the first week
- practical help if needed
- employment support.

NICE NG53 recommendation 1.6.7

Follow up a person who has been discharged within 7 days.

NICE NG53 recommendation 1.6.8

Follow up a person who has been discharged within 48 hours if a risk of suicide has been identified.

4.3.3 Current UK practice

Named coordinator

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Timing of follow-up

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Continuing therapies

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

4.3.4 Resource impact assessment

This area was not included in the resource impact assessment for NG53. It was not identified as an area that would have a significant resource impact (>£1m in England each year).

4.4 Support for families, parents and carers

4.4.1 Summary of suggestions

Sharing information with families, parents and carers

Stakeholders highlighted that information should be shared with families, parents and carers to help to support a smoother transition for the person. This should apply if the person is subject to the Mental Health Act, and if the person does not have capacity to make decisions.

Carers' assessments

A stakeholder highlighted that carers should be offered an assessment of their own needs, given the emotional and psychological impact of being a carer, to reduce the risk of them developing care needs themselves.

4.4.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 8 to help inform the committee's discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Sharing information with families, parents and carers	**Sharing information with families, parents and carers** NICE NG53 recommendations 1.4.5 and 1.4.6 **Involving families and carers** NICE CG136 recommendation 1.1.16
Carers' assessments	**Carers' assessments** NICE NG53 recommendation 1.4.10

Sharing information with families, parents and carers

NICE NG53 recommendation 1.4.5

Respect the rights and needs of carers alongside the person's right to confidentiality. Review the person's consent to share information with family members, carers and other services during the inpatient stay. For more information, see the subsection on involving families and carers in NICE's guideline on service user experience in adult mental health services.

NICE NG53 recommendation 1.4.6

Throughout admission, give families, parents or carers clear, accessible information about:

- the purpose of the admission
- the person's condition (either general, or specific if the person agrees to this)
- the treatment, care and support that the person is receiving
- the inpatient unit, including:
    - the ward and the wider hospital environment
    - the practicalities of being in hospital
    - resources that are available, including accommodation for families
    - visiting arrangements
- preparing for discharge.

Involving families and carers

NICE CG136 recommendation 1.1.16

If the person using mental health services wants their family or carers to be involved, give the family or carers verbal and written information about:

- the mental health problem(s) experienced by the service user and its treatment, including relevant text from NICE's information for the public
- statutory and third sector, including voluntary, local support groups and services specifically for families and carers, and how to access these
- their right to a formal carer's assessment of their own physical and mental health needs, and how to access this.

Carers' assessment

NICE NG53 recommendation 1.4.10

Identify carers (including young carers) who have recognisable needs. If the carer wishes it, make a referral to the carer's local authority for a carer's assessment (in line with the Care Act 2014). Ensure a carer's assessment has been offered, or started, before the person is discharged from hospital.

4.4.3 Current UK practice

Sharing information with families, parents and carers

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Carers' assessments

An audit of the quality of inpatient care for adults with learning disability was carried out across 15 hospitals in 2013/14 in England and Wales[1]. The audit included six mental health services. Across the mental health services, in 24% (10/41) of cases, there was evidence in the case notes that the patient's informal carer had been signposted to an assessment of their needs before discharge.

4.4.4 Resource impact assessment

This area was not included in the resource impact assessment for NG53. It was not identified as an area that would have a significant resource impact (>£1m in England each year).

[1] Sheehan R, Gandesha A, Hassiotis A, et al. An audit of the quality of inpatient care for adults with learning disability in the UK. BMJ Open 2016;6: e010480. doi:10.1136/ bmjopen-2015-010480

4.5 Additional areas

Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the committee to establish potential for statement development.

There will be an opportunity for the committee to discuss these areas at the end of the session on 5th January 2017.

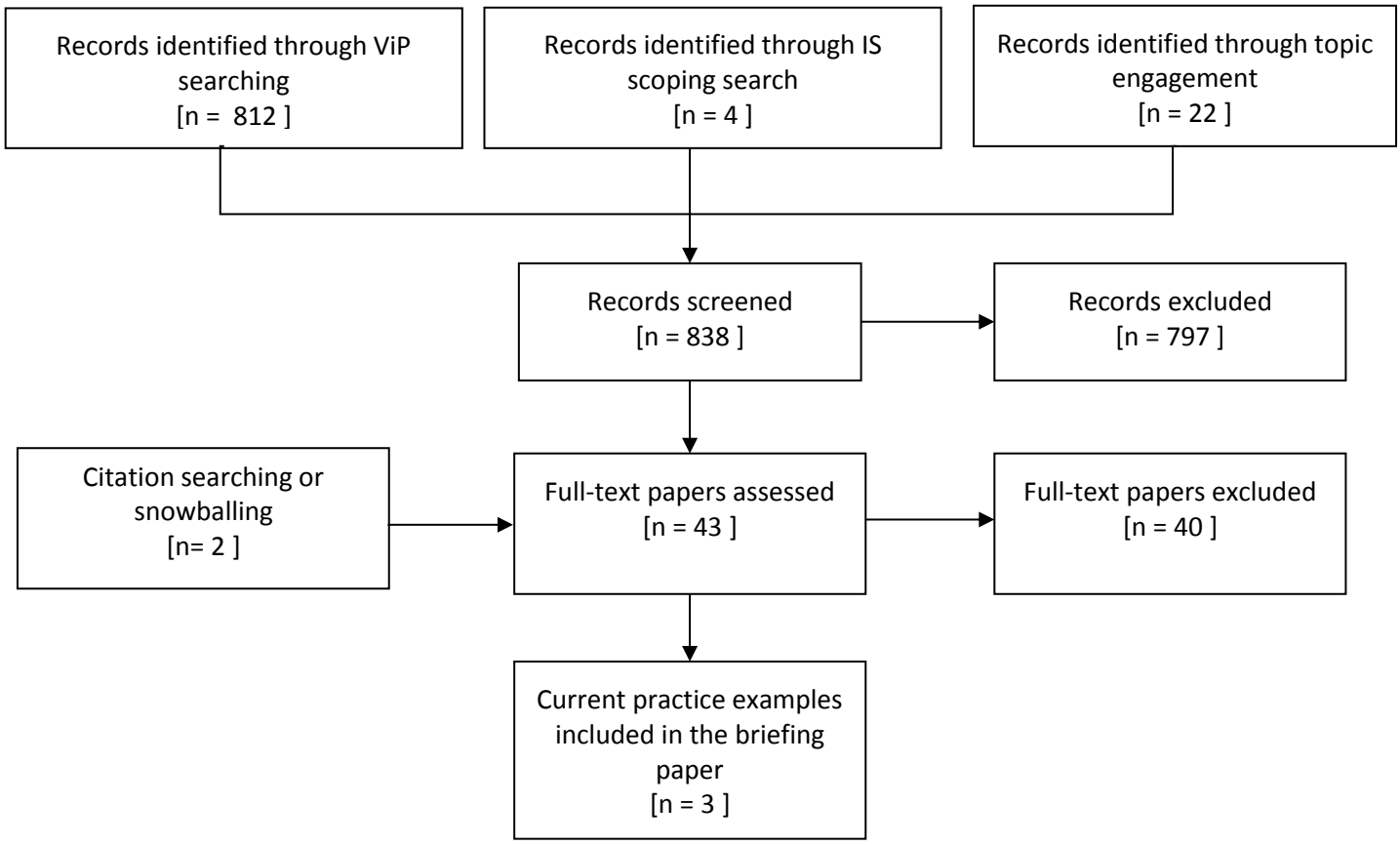
National database of community mental health teams

A stakeholder suggested that there should be a national database of community mental health teams in England so that teams can find who to contact about someone's transfer of care, including if they move to a different area of the country. This area is not contained in the development source.

Addressing the needs of black and minority ethnic groups

A stakeholder highlighted that some black and minority ethnic groups are more likely to be admitted to hospital and have longer stays, more likely to be detained under the Mental Health Act and more likely to be discharged onto a community treatment order. The impact on specific equality groups will be considered throughout the development of the quality standard.

Appendix 1: Review flowchart



Appendix 2: NHS Improvement patient safety report

Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
Discharge from mental health acute care services	Between October 2012 and September 2013 there were around 10,000 reports to the National Reporting and Learning System (NRLS) of patient safety incidents related to discharge. The handover of patients when discharged from secondary to primary, community and social care is a complicated and multifactorial process.	Communication at handover is identified as a particular area of risk and accounted for approximately 33% of the 10,000 incidents reported to the NRLS. Review of these incidents identified that patients are sometimes discharged without adequate and timely communication of essential information at point of handover to all relevant staff and teams in primary and social care, including out of hours, and that information is not always acted on in a timely manner. This can result in avoidable death and serious harm to patients due to a failure in continuity of care as well as avoidable readmission to secondary care. Approximately 150 of these incidents were relevant to patients discharged from mental health acute care. A Patient Safety Alert 'Risks arising from breakdown and failure to act on communication during handover at the time of discharge from secondary care' was issued in 2014 with an action for organisations to share examples of local best practice.	The NRLS data analysis Patient Safety Alert Case Studies Standards for the communication of patient diagnostic test results on discharge from hospital can be found at: https://www.england.nhs.uk/patientsafety/discharge/

Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		A collaborative programme of work was then undertaken with the Patient Safety Collaboratives number of case studies of local best practice were subsequently produced and published. Standards for the communication of patient diagnostic test results on discharge from hospital were developed and published in 2016 which again are relevant to mental health services. These are endorsed by the Academy of Medical Royal Colleges.	

Appendix 3: Suggestions from stakeholder engagement exercise – registered stakeholders

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
Hospital admission					
1	Parkinson's UK	Key area for quality improvement 1 Incorporation of medicines management protocols	Parkinson's is a condition which requires medication to be taken at very specific times. Missing medication, even by a very short period of time, can have a detrimental impact on a person's condition. We therefore strongly support in the *NICE Clinical Guideline Transition between inpatient mental health settings and community or care home settings* the recommendation that at admission, a senior healthcare professional discusses all medication needs (1.3.19). The quality standard must ensure that professionals fully understand the importance of timely medication administration for people with Parkinson's and that there are no barriers to accessing timely medication.	People with Parkinson's face difficulties in receiving their medication on time, in all care settings. In a survey of people with Parkinson's, 33% said most of the time they got their medication on time, but not always, with a further 18% saying only sometimes did they get their medication on time. Almost 14% of patients rarely or never got their medication on time whilst in hospital. Furthermore, an audit of Parkinson's services across the UK in 2015 highlighted that only 50% of patients reported getting their medication consistently on time whilst in hospital.	Parkinson's UK. *Final report – Your Life Your Services* 2015. Parkinson's UK. *2015 UK Parkinson's Audit.* Summary Report. 2015.

2	Parkinson's UK	Key area for quality improvement 4 Continued access to multi-disciplinary teams throughout transition	For people with Parkinson's, in addition to their mental health needs being taken into account during admission to inpatient mental health services, it is important that the maintenance and management of other health issues are taken into account, including other symptoms of Parkinson's. During all stages of transition, it is important that there is access to trained professionals, which should include speech and language therapists, occupational therapists, physiotherapists and Parkinson's nurses.	Access to a multi-disciplinary team is important at all stages of Parkinson's, not just the early stages. For example, services provided by an Occupational Therapist (OT) can benefit people throughout their condition, for example targeted physical activity training on motor performance, postural stability and balance. A recent audit of Parkinson's services highlighted that access to a full multi-disciplinary team of professionals is limited, with only 13% of services able to offer a fully integrated clinic model. It is important that people with Parkinson's are able to access multi-disciplinary teams across different health and care settings. The NICE clinical guideline Parkinson's disease in over 20s: diagnosis and management (2006) which is currently being updated recommends that people with Parkinson's should be able to access specialist nursing care, physiotherapy, occupational therapy and speech and language therapy and palliative care.	Parkinson's UK. *2015 UK Parkinson's Audit.* Summary Report. 2015. NICE guideline for Parkinson's disease: National clinical guideline for diagnosis and management in primary and secondary care. 2006.
3	RCGP	Key area for quality improvement 1	Better communication between teams, and include university health GP team, at a geographical distance, in correspondence. Clarity of where responsibility lies for following up and ensuring not lost in system		
4	SCM1	Key area for quality improvement 2: Specialist CAMH provision is available within a 50	The impact on the young person of being placed far away from their support network of family, friends and education is noted	HA 10 The GC felt information on treatment and services should be available to people at the point that they need it. Expert witness from Young Minds suggested that issues around admission were exacerbated when young people were placed further from home	Royal College of Psychiatrists Faculty of Children and Adolescent Psychiatry (2015) Survey of in-patient admissions for children And young people stuck in the gap between Community and in-patient care.

		mile radius of the young person's home			
5	SCM2	Allow more time and expert input to support people with complex, multiple or specific support needs to make transitions to and from services, if necessary.	This is recommended in the NICE guidance	In my professional experience this can contribute to ensuring a successful transition – both into and out of hospital.	
6	SCM2	The named practitioners from the person's home area and the ward should work together to ensure that the person's current placement lasts no longer than required. This should include reviewing the person's care plan, current placement, recovery goals and discharge plan at least every 3	Recommendation in NICE guidance.	Although many recent guidelines have suggested that out of area placements should be reduced there are still people in placements a long distance from their home area and that they are often not supported as effectively and spend longer in hospital.	

		months, or more frequently according to the person's needs. This could be done in person or by audio or videoconference.			
7	SCM3	Key area for quality improvement 2	Advocacy	Due to the important role that Independent Mental Health Advocates (IMHA) play, we also carried out a specific review of the way services were making sure that patients could access support from advocacy. We asked 210 wards how they monitored the use of the IMHA service and the support and training offered to staff on the safeguards offered by advocacy. In total, 171 wards told us they did not keep a record of the referrals made, and 82 wards had not received training on the role of the IMHA or how to refer a patient. This is a serious concern for us and we make specific challenges to providers and the Department of Health in the involvement section of this report to address this issue. Issues with staff training and support have been a concern in many of our visits, with wide variation in the provision or uptake of MHA training. Making sure that staff have the right skills and knowledge they need around their roles and duties under the MHA, and ensuring that the right training is provided would address many of the problems we have found.	Wording from: http://www.cqc.org.uk/sites/default/files/20151209_mhareport2014-15_summary.pdf

8	SCM4	Key area for quality improvement 2	Building therapeutic relationships as early as possible in considering admission, especially where this may be under the Mental Health Act, can reduce the experience of coercion, and encourage collaborative work on therapeutic input and care planning for successful discharge.	Negative experiences of the admission process can work against engagement of the individual and family in the treatment programme. Negative experiences can be associated with suicide, which is a high risk in the weeks around admission or discharge. The stigma attached to being admitted to a mental health service can be harmful, and in some cultures it is very significant. (The equality impact assessment might usefully make this point; the Guideline may advance Equality for those people who are disabled by virtue of mental ill health.)	Confidential Inquiry into Suicide
9	SCM4	Key area for quality improvement 3	Creating the structures to prioritise effective team work across social care, mental health community services, in-patient services and specialist supports including those for young people in education, people with a learning disability, those with complex psychosis, dementia or other cognitive impairment.	Poor collaboration can result in poor assessment and discharge planning, negative effect on the individual and their family and inefficiency across the public sector.	
10	SCM4	Key area for quality improvement 4	Placements out of the individual's home area bring risks of fragmentation of care and treatment, longer than necessary stays in hospital, and risk of institutionalisation and slower recovery. Also significant excess cost.	Close collaboration is of particular importance in out of area placements. Careful communication prior to, during, and as discharge is planned and completed are key points when individuals and families may be at additional risk of sub-optimal treatment and support.	See RCP publications on out of area treatment

11	Mind	Welcome, hospitality and information on admission to hospital	How someone is received into a service sets the tone for their stay, and the provision of induction information may help people feel less anxious, vulnerable or confused. The guideline (1.3.18) promotes giving the person information about the ward on admission. Other recommendations (provision of toiletries etc, developing therapeutic relationships) may be supported by an overall ethos of hospitality. In a YouGov survey carried out for Mind in 2015, people who had received induction information were more likely to feel safe in hospital. This could be because having this information makes people feel safer or because hospitals with good practice in this area have good practice in others too, or both.	In our YouGov survey only 40 per cent of people who had been inpatients received induction information; 36 per cent didn't and 25 per cent didn't know. (The base for that question was 210 people.) This suggests that this is not widespread, routine practice and should therefore be improved.	In the YouGov survey, excluding don't knows, 31 per cent of people who had been inpatients felt unsafe in hospital and 69 per cent felt safe. Half (51 per cent) of those who didn't receive information felt unsafe compared with 16 per cent of those who did.
Hospital discharge					
12	RCGP	Key area for quality improvement 3	National template for transfer form should be designed and used, can be scanned into electronic GP/ CMHT/ eating disorders team record, carried by patient and sent electronically to relevant teams.		
13	RCGP	Key area for quality improvement 4	Should develop online patient record, like Maternity patient held record, but on phone/ ipad/ laptop for ease of care/ access/ updating, and patient involvement. All inpatients then have such record created for them, ready for transfer. The current contractual requirements for Online access may help with regard to this.		
14	Faculty of Old Age Psychiatry, RCPsych	Key area for quality improvement 3 Discharge planning	Appropriate early discharge planning is crucial for all patients, but especially older people to ensure that relevant factors for maximising independence at home or successful care home placement are identified early with appropriate action plans implemented to maximise the chances of successful discharge.	Due to cost and bed pressures, older patients are too often inappropriately placed in an unsuitable care home too early, often resulting in crisis readmissions, sometimes within hours or days. Appropriate discharge planning that allows a gradual testing out/leave or visits to identified care home is important to minimise this risk.	The Kings fund - Making our health and care systems fit for an ageing population. 2014

15	SCM1	Key area for quality improvement 4 Patients' GP and CPN teams are provided with information from the discharging hospital within an agreed time following discharge	Provision of the most current information relating to medication, future out -patient appointments and on-going treatment plans can help to ensure that the patient receives the follow up care as agreed prior to discharge	HA13, HA10 Service user experience in adult mental health services guidelines (NICE guidelines CG 136) GC recommend that a copy of the care plan be sent to everyone involved in providing support to the person at discharge and afterwards: to include : Details of medication (see recommendations on medicines -related communication systems in NICE's guidelines on medication optimisation	Fontanella CA et al. (2010) Effects of medication management and Discharge planning on early readmission Of psychiatrically hospitalised Adolescents.
16	SCM1	Key area for quality improvement 5 Psychoeducation to be provided for those experiencing second or more readmission	The value of psychoeducation for those experiencing on going mental health conditions can help to prevent reoccurrence of symptoms and an awareness of the importance of continuing with treatment /therapy programmes	GC recommend that before discharge offer a series of individualised psychoeducation sessions for people with psychotic illnesses to promote learning and awareness. Also consider psychoeducation sessions for all people with other diagnosis as part of planning discharge and avoiding readmission	Pitschel-Walz G et al. (2006) Psychoeducation and compliance in the Treatment of schizophrenia : results of the Munich Psychosis Information Project Study
17	SCM3	Key area for quality improvement 1	Discharge planning	Lack of evidence of discharge planning – 1,052 out of 3,675 (29%) care plans reviewed did not show any evidence of discharge planning. This is better than in 2013/14, when the equivalent measure showed that 38% of records seen had no evidence of discharge planning	Wording from: http://www.cqc.org.uk/sites/default/files/20151209_mhareport2014-15_summary.pdf

18	SCM4	Key area for quality improvement 1: Person centred assessment, and care planning focussed on recovery	Fully understanding the individual's circumstances, strengths and the issues that are important to them may enable treatment to be better tailored and more likely to be accepted by individual, family and carers. An orientation towards maximising strengths and working jointly on the aims for recovery may reduce length of stay an improve community outcomes.	Evidence on variability of lengths of stay and readmission rates which may be associated.	Royal College of Psychiatrists; ImRoC,
19	SCM4	Key area for quality improvement 5	Close and collaborative follow up post-discharge is particularly important for those who have been at risk of suicidal actions or thoughts.	There is a higher risk of suicide in the 7 days post-discharge. Discussion with the individual and family, and explicit care planning to ensure appropriate support is necessary. Psycho-education for individuals and families should be considered prior to and post-discharge.	Confidential Inquiry
20	NCD	Community workers already involved with the patient have not stayed in touch with the patient – they should have been visiting and helping prepare for discharge			National audit of psychosis
21	NCD	3. Medicines are often poorly communicated to GP			
22	NCD	4. GPs get poor information generally, this is especially			

		important for older people			
23	Mind	Addressing people's housing and other practical concerns	Making sure that people's living arrangements are looked after while they are in hospital is extremely important. It should never happen that someone is made homeless by a hospital admission, or is discharged to an unsafe living situation. Where people are already homeless or not getting the support they need, putting that support in place and helping to secure accommodation will help to promote their recovery and to prevent future crises, as well as fulfilling a basic need. These issues appear at various points in the guideline - accommodation (1.5.7 and 1.5.8), domestic arrangements (1.3.20), preparing for discharge (1.5.21) and follow-up support (1.6.1)	This area is made more challenging because it often involves more than one agency and because advice, support and housing services are under great pressure. Healthwatch England's 2015 *Safely home* inquiry highlighted the human cost of poorly coordinated services and lack of attention to the full range of people's needs (among other issues).	Healthwatch England - http://www.healthwatch.co.uk/safely-home St Mungo's research - http://www.mungos.org/documents/7430/7430.pdf
24	Mind	Care and discharge planning	This is fundamental to good transitions as well as good care. It is through the planning process that needs are assessed, the person and any carers are heard and given the information they need, and arrangements for care to be delivered are made.	The CQC's community mental health survey 2015 identifies care planning as a continuing area for improvement – including knowing who is responsible for your care and having an agreed plan of care.	
25	Mind	Active partnership in care and discharge planning	Involving people fully in planning care and discharge should improve people's experience and make it more likely that people are discharged safely and at the right time. This relates to the over-arching principles and care and discharge planning sections of the guideline.	People tell us about having difficulty in accessing help in crisis (though this should be improving through the Crisis Care Concordat) especially if they feel they need hospital admission. In a YouGov survey carried out for Mind, 70 per cent of those who had received inpatient treatment agreed that they left at the right time but 7 per cent said they should have been discharged earlier and 23 per cent said they were not well enough to be discharged.	The CQC community mental health survey 2015 shows that involvement in care continues to be a key area for improvement – "Of those who had agreed with someone from NHS mental health services what care they would receive: 56% were 'definitely' involved as much as they wanted to

				This was also a key issue in Healthwatch England's *Safely home* inquiry, where people did not feel fully involved in decisions. The pressure on services, which is set out in the report of the Acute adult psychiatric care and Five year forward view for mental health means that the people receiving care can also feel under pressure and be discharged with little notice or preparation because someone who is more ill needs the bed.	be in agreeing what care they will receive."
Follow-up support					
26	Faculty of Old Age Psychiatry, RCPsych	Key area for quality improvement 1 Integrated care/Single point of access or contact	Patients/Carers transitioning between Inpatient mental health care and the Community often do not know who or where to contact to access services and support. There is often a disconnect between services provided by the local authority and health care services.	Having an integrated with a single point of contact or access would reduce the risks of repeated crisis admissions and use of 999/Emergency services including A and E, and would help with discharge support after inpatient admission to coordinate community support and prevent readmission.	London mental health crisis commissioning: Case studies, 2014
27	Faculty of Old Age Psychiatry, RCPsych	Key area for quality improvement 2 Care coordination to support discharge and care home placement	A lack of information including positive information flow that could allow early identification of relapse signatures and early treatment can prevent hospital admission but also ease transition back into the community or into a care home after hospital discharge could be effectively managed with a named care coordinator to support discharge for 28 days,	This support could ideally be provided via the crisis teams taking responsibility on a named care coordinator basis in essence providing intermediate care for each patient after discharge to maximise the chances of recovery.	RIGHT PLACE, RIGHT TIME BETTER TRANSFERS OF CARE: A CALL TO ACTION 'Doing the obvious thing is the radical thing' NHS providers 2015
28	SCM1	Key area for quality improvement 3 Named practitioners /or a deputy in their absence is provided for each person requiring in-patient mental	The value of providing consistency of care and information is significant in the provision of mental health care	HA 14 Ensure there is a designated person responsible for writing the care plan in collaboration with the person being discharged If a person is being discharged to a care home,, involve care home managers and practitioners in care planning after they are discharged	Omer S et al. (2014) Continuity across inpatient and outpatient Mental health care or specialisation of Teams : suggests better outcomes and Stakeholder preferences for continuity of Care systems

		health care to support transition phases in the future			
29	SCM2	Follow up a person who has been discharged within 48 hours if a risk of suicide has been identified.	Suicide risk is increased in people who have been admitted to hospital		
30	SCM4	Key area for quality improvement 5	Close and collaborative follow up post-discharge is particularly important for those who have been at risk of suicidal actions or thoughts.	There is a higher risk of suicide in the 7 days post-discharge. Discussion with the individual and family, and explicit care planning to ensure appropriate support is necessary. Psycho-education for individuals and families should be considered prior to and post-discharge.	Confidential Inquiry
31	NCD	2. The period after discharge (2 weeks) is a period of high risk of suicide and requires careful follow-up and continued engagement			National confidential inquiry into suicide and homicide
32	NCD	5. Talking therapy begun on the ward is often not continued when it should be.			
Support for families and carers					

33	Parkinson's UK	Key area for quality improvement 3 Carers assessment and wellbeing	Carers of people with Parkinson's are frequently friends and family members and are likely to be heavily involved throughout the admission process (whether it was planned or not) and during discharge. It is crucial that practitioners involved in both admission and discharge and throughout the process take into account carers' needs and are proactive in offering to link them up with their Local Authority for a carer's assessment.	Given the significant emotional and psychological impact on carers of supporting someone with Parkinson's, carers should have regular assessments of their needs. Practitioners must be proactive in identifying carers' needs to prevent them from developing care needs themselves. By including carers' assessment and wellbeing in this Quality Standard, it will help to ensure that the needs of friends and family members are considered throughout the whole transition process from admission to discharge.	In 2016, Parkinson's UK conducted research to examine how social care is working for people with Parkinson's and carers in England. It found that: No carer surveyed received access to preventative support or respite care to help them manage caring responsibilities 76% of carers who answered the question "have you ever been offered an assessment of your own needs?" had never received an assessment Parkinson's UK, Caring about Parkinson's: how local authority social care services are working for people with Parkinson's and carers in England. January 2016. https://www.parkinsons.org.uk/sites/default/files/care_act_experience_report.pdf
34	Parkinson's UK	Key area for quality improvement 5 Where the person does not have mental capacity, ensure the involvement of carers, friends and family throughout admission and discharge	Where possible, it is imperative to include people in their own care and decision-making. However, if people are unable to make decisions, it is important that carers and families are involved in decision-making to ensure the individuals wishes are taken on board. This quality standard must emphasise the importance of ensuring that professionals consult with the relevant individuals as set out in recommendations in *NICE Clinical Guideline Transition between inpatient mental health settings and community or care home settings.*	People with Parkinson's often experience mild memory loss, mild cognitive impairment and dementia. Up to 80% of people who have lived with Parkinson's 20 years or more may develop dementia. Carers and family members of those with Parkinson's are very often the experts in the person's condition regarding symptoms, medicines and many other aspects, therefore, their information and opinions should be taken into account by professionals.	Yarnall, A, Archibald N and Burn, D "Parkinson's disease." *Neurology* 40.10 (2012): 529-535

35	SCM1	Key area for quality improvement 1 People are provided with essential information during all transition phases	The value of providing patients/carers/relatives with information at all stages of transition is significant and helps to support a smoother transition and stay in hospital for the individual. Respect the rights and needs of carers alongside the person's rights to confidentiality.	See NICE Guideline on service user experience in adult mental health services HA 6, HA 9, HA 14 , DC 16, CYP1 , NICE guidelines CG 136 The GC feel that communication between community teams and liaison with diverse in-patient teams was essential for continuity of care Throughout admission, give families, parents, or carers clear, accessible information.. also in a format that can be understood	Wilkinson C, McAndrews S (2008) I'm not a outsider, I'm his mother!". A Phenomenological enquiry into carer Experiences of exclusion from acute Psychiartric settings
36	SCM3	Key area for quality improvement 3	Involvement in care and treatment for people subject to MHA, including from carers	The biggest issue we found for patients who were subject to the MHA in 2014/15 was a lack of support to be involved in their care and treatment. This included the information they were given, access to external support such as advocacy, and care planning. We are concerned by this finding, as not supporting patient, family and carer involvement may limit people's recovery and could result in longer stays in hospital, poor discharge or an increase in the potential for readmission.	Wording from: http://www.cqc.org.uk/sites/default/files/20151209_mhareport2014-15_summary.pdf

37	Parkinson's UK	Key area for quality improvement 2 Assess drug combinations and seek specialist advice about medicines	Healthcare professionals should seek advice about medicines from people with specialist experience in Parkinson's. Many people with Parkinson's may have other long-term conditions, including dementia. As a result, the number of medications required can be very complex and some medicines can react badly when taken with others. We would recommend that the quality standard highlights the importance of completing a medication review when someone is admitted to ensure all medications a new patient is taking and their interactions are noted. Medication should then be reviewed at regular intervals, not just at admission, to ensure that medicine prescribed is working effectively.	Parkinson's medication can easily react to other medication. For example, many people with Parkinson's can be very sensitive to neuroleptic (antipsychotic) drugs which can be used to treat dementia.	Drug treatments for Parkinson's https://www.parkinsons.org.uk/content/drug-treatments-parkinsons
Additional areas					
38	RCGP	Key area for quality improvement 2	National data base needed of all CMHT for England/ counties so local teams can find who to contact re transfer of care if not local, e.g. eating disorder services, when leaving inpatient unit, to move to different area of country for university next		
39	Mind	Addressing the needs of people from over-represented Black and minority ethnic groups	The over-representation of some BME groups suggests that they may not be getting support early enough. Longer stays in hospital may indicate being less well but may also indicate less therapeutic input and social inclusion and potentially more risk-averse decision-making. Therefore, implementation of the guideline needs to be appropriately tailored to BME service users and equally effective for them.	Some BME groups are more likely to be admitted to hospital and to be detained under the Mental Health Act, to be discharged on to a community treatment order, and to stay longer in hospital - Mental Health Bulletin 2014-15 (NHS Digital)	

Other					
40	Tees, Esk and Wear Valleys NHS Foundation Trust	Timeliness of Transition			
41	SCM3	Additional evidence sources for consideration	Named social worker pilots. According to the Chief Social Worker, adults: The pilots are running in six areas: Calderdale, Camden, Hertfordshire, Liverpool, Nottingham and Sheffield and a fantastic opportunity to constructively challenge clinical teams as they seek to make decisions about a person's care and support. More importantly, the individuals and families we are tasked to help will receive the benefit of our person-centred approach, whether they are living in clinical or community environments and to realise the vision set out in the Government's response to the No voice unheard, no right ignored consultation https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/409816/Document.pdf		
42	Royal College of Paediatrics and Child Health	Our commenter felt satisfied with the content of the draft document.			
43	Department of Health	The Department of Health will not be submitting any comments regarding this topic engagement.			
44	NHS England	I would like to confirm that NHS England has no comments with regards to the above Quality Standard. Many thanks for the opportunity to comment on this quality standard.			
45	Royal College of Nursing	This is to inform you that the Royal College of Nursing has no comments to submit to inform on the above topic engagement at this time. Thank you for the opportunity, we look forward to participating in the next stage.			

Appendix 4: Suggestions from stakeholder engagement exercise – respondents with links to the tobacco industry

ID	Stakeholder. Registration status and disclosed link.	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
1	St Mungos St Mungo's has received donations from British American Tobacco, most recently an unrestricted donation of £31,420 in February 2016. Unrestricted donations are used to help fund a range of St Mungo's charitable activity. We have no other links with the tobacco industry.	Accommodation for people leaving inpatient mental health services	There is evidence that people are rough sleeping after being discharged from inpatient mental health services. Rough sleeping is dangerous and places people at risk of harm and relapse, and also makes access to further mental health support more difficult. Discharge planning and intensive, structured support for people with serious mental health issues to find and keep accommodation is recommended within NICE guidance.	A national survey of street outreach workers by St Mungo's found that 78 per cent professionals said that in the last 12 months they had met at least one person sleeping rough who had recently been discharged from a mental health hospital. A Healthwatch England investigation into hospital discharge found that people were discharged straight to the street, experienced a lack of coordination between services, were left without the support they needed after discharge and did not have their housing situation taken into consideration.	Please see the recent St Mungo's investigation into mental health and rough sleeping for analysis of data on people sleeping rough and results from our survey of street outreach professionals: http://www.mungos.org/documents/7021/7021.pdf The Healthwatch England special inquiry into discharge from hospital settings engaged with 200 people with experience of homelessness: http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/170715_healthwatch_special_inquiry_2015_1.pdf