# NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

# Guideline scope

## 1 Guideline title

Transition between inpatient mental health settings and community or care home settings

## 2 Remit and background

The National Institute for Health and Care Excellence (NICE) has been asked by the Department of Health to develop a guideline on the transition between inpatient mental health settings and community or care home settings for children, young people and adults. The guideline will cover both:

- admission to inpatient mental health settings from community or care home settings; and
- discharge from inpatient mental health settings to community or care home settings.

This guideline will provide recommendations about actions to improve practice, aimed at improving outcomes for people using health and social care services and their families or carers. The guideline is based on the best available evidence of effectiveness, including cost effectiveness. It is relevant to people using health and social care services, carers, communities, care providers (including independent and voluntary sector providers), health and social care practitioners and commissioners (including people who purchase their own care).

NICE guidelines provide recommendations on what works in terms of both the effectiveness and cost effectiveness of interventions and services. This may include details on who should carry out interventions and where. However, NICE guidelines do not routinely describe how services are funded or

commissioned, unless this has been formally requested by the Department of Health.

This guideline will complement NICE guidelines on a range of topics including the transition between inpatient hospital settings and community or care home settings for adults with social care needs and transition from children's to adult services. For details see section 5 (related NICE guidance).

# 3 Need for the guideline

## *3.1 Key facts and figures*

3.1.1 Poor transition between inpatient mental health settings and community or care home settings has negative effects on people using the services, their families and communities. A major issue affecting transitions between inpatient mental health settings and the community is a lack of integrated and collaborative working between health and social care. Poor planning can lead to lack of continuity, personalisation and the necessary support for the person with mental health problems and their family.

3.1.2 Delays in transferring people from an inpatient mental health setting may mean that they remain in hospital unnecessarily after they have been assessed as ready to go home (or to another setting). In a postal survey of mental health trusts (Lewis and Glasby 2006), a wide range of interrelating factors were identified as contributing to delayed discharges. This included a lack of funding for ongoing support and awaiting assessment for support, care home placement and further NHS funding. A more recent study of one inpatient mental health service in England provides similar findings. The reasons identified for delayed discharges included a lack of available beds, failure to find a suitable facility, awaiting a funding decision and delays in implementing a care package for support at home.

3.1.3 Although there is some research into the extent and causes of delayed transfers of care from inpatient mental health settings, official monitoring and routine data collection is limited. The scale of the problem is therefore difficult to estimate.

3.1.4 The University of Manchester's recent National Confidential Inquiry into Suicide and Homicide by People with Mental Illness found that, between 2002 and 2012, 3225 mental health patients died by suicide within the first 3 months of their discharge from hospital (University of Manchester, 2014). The peak time for risk of suicide is one week after leaving hospital. The report underlines the need for careful and effective care planning before discharge and for more support, including early follow-up appointments, after discharge. In recognition of the consequences of poor aftercare, figures published from 2014–15 in the Clinical Commissioning Group (CCG) outcomes data set will include readmission to mental health settings within 30 days. Emergency readmissions are used in the CCG figures as a proxy for outcomes of aftercare.

3.1.5 It is important to note that uncoordinated admission to inpatient mental health settings and avoidable admissions to residential or nursing care from hospital are also important examples of poor transitions.

3.1.6 Research examining attempts to improve transitions focuses mainly on the effects at the service or system level, namely inpatient bed days, discharge and readmission rates and hospital and community mental health service costs (Sledge et al, 2011 and Byford et al, 2010). Where research examines the effect on individuals, it generally focuses on functional ability, quality of life, psychopathology and the experiences of people who use mental health services, especially during admission and crisis (Gilburt et al, 2008 and Longo, 2004).

## *3.2 Current practice*

3.2.1 Transition can be particularly difficult for certain groups in society including: people with communication difficulties and/or sensory impairment; people who live alone; and people of minority ethnic background especially if there is inadequate planning and support. People placed out of area experience particular difficulties, including less contact with family and friends, social exclusion, and reduced opportunities for employment and education (Rethink & Care Services Improvement Partnership, 2007). Furthermore, from an organisational perspective, where the independent sector provide a significant proportion of the mental health beds in England, there are implications in terms of case management and monitoring people for discharge when placed in specialist beds out of area.

3.2.2 When inpatients remain in hospital after they have been assessed as fit as ready to go home (or to another setting), there are negative consequences for the person and the system. A poor transition creates significant anxiety, leaving people uncertain about their diagnosis and support. They can also become dependent on inpatient care and subsequently lose coping skills on discharge. Key personal relationships may be damaged and housing or jobs may also be lost.

3.2.3 When transfers are delayed, hospital wards can become overcrowded leading to insufficient staff being available, or those that are there being overstretched. This can result in an increase in serious incidents, delays in admitting 'at risk' patients or the premature discharge of others and negative effects on staff morale, retention and recruitment (A positive outlook: a good practice toolkit to improve discharge from inpatient mental health care NIMHE, 2007). A lack of integration is a key cause of delayed discharges, both when inpatient and community mental health services do not

work together effectively and when there is a lack of interagency working between health, social care and housing (CSIP, NIHME, 2007). It is also acknowledged that a lack of community facilities and therapeutic options make the problem worse.

3.2.4 Guidelines on transitions generally focus on admission into or discharge from inpatient mental health settings. They fall into two categories: guidelines describing what people should expect (and are entitled to) in relation to their transition; and guidelines to raise awareness and improve practice among professionals involved in transition processes and cross-sector working, across housing, health and social care.

## *3.3 Policy, legislation, regulation and guidance*

### 3.3.1 Policy

- A key part of the UK mental health system, the Care Programme Approach was introduced in 1990 as the UK model for assessing, planning and reviewing care for people with mental health needs. The most recent update placed emphasis on supporting only people at higher risk or with more complex needs through the (new) Care Programme Approach (Refocusing the Care Programme Approach, Department of Health, 2008).
- Children and young people can also receive treatment and support through this approach. It can be especially helpful where they are supported by specialist child and adolescent mental health services (CAMHS). Local protocols are needed to agree which system has the lead responsibility for child protection or mental health and other considerations such as taking a family centred (rather than person centred) approach to care planning are important in this context (Department of Health, 2008).
- The National Service Framework for Mental Health (Department of Health 1999) set out a ten-year agenda for improving mental health care in England, specifically in relation to services for working age adults. The policy had a significant impact on service provision, including the

establishment of three functional teams; assertive outreach, early intervention in psychosis and crisis resolution and home treatment (CRHT) teams. These teams have particular significance for the scope of this guideline because they play a key role in preventing unnecessary admissions and supporting people on discharge from hospital.

### 3.3.2 Legislation

- The Mental Health Act 1983 (amended by the Mental Health Act, 2007) has specific relevance to the scope of this guideline. It is the law that governs the involuntary admission, treatment and detention of people in mental health inpatient settings. The Mental Health Act also covers discharge from inpatient mental health settings. Section 117 entitles someone to free aftercare when they are discharged from hospital under certain sections of the Act. The NHS and the local social services authority provide free aftercare including help to meet needs relating to housing, socialising, employment, education plus free prescriptions for mental health treatment.
- Where people receiving treatment within an inpatient setting are there on a voluntary basis, the Mental Health Act covers neither their admission nor discharge but other legislation applies. The NHS and Community Care (NHSCC) Act 1990 is relevant to the support of people receiving treatment who are in an inpatient setting on a voluntary basis. It requires health and local authorities to put in place a set of arrangements for the care and treatment of people with a mental health problem in the community.
- The Care Act 2014 introduces new rules intended to make social care more personalised, fairer across the country and more supportive of carers. It seeks to ensure that people's wellbeing and the outcomes which matter to them are at the heart of every decision that is made. Examples of provisions of the Act relevant to transitions between inpatient mental health settings and the community are, a new right to advocacy to help people navigate the care and support system and the introduction of a specific definition of 'after care services'.
- A range of other policy and legislation is relevant to supporting people during transition between inpatient mental health settings and community

or care home settings have been published by the Department of Health or HM Government, including:

- The Better Care Fund (2013)
- Caring for our future: reforming care and support (2012)
- Health and Social Care Act (2012)
- The Mental Capacity Act (2005)

# 4 What the guideline will cover

This guideline will be developed according to the processes and methods outlined in The social care guidance manual. This scope defines exactly what this guideline will (and will not) examine and what the guideline developers will consider.

## *4.1 Who is the focus?*

### 4.1.1 Groups that will be covered

- All children, young people and adults in transition between inpatient mental health settings and community or care home settings.

Protected characteristics under the Equality Act 2010 have been considered during scoping through the completion of an equality impact assessment. This will be published alongside the final scope.

### 4.1.2 Groups that will not be covered

- People moving between inpatient mental health settings (for example from a medium secure to a low secure bed).
- People moving between prison or a young offenders' institution and an inpatient mental health setting.
- People moving between prison or young offenders' institution and a community or care home setting.
- Children and young people moving from children's to adult services unless a transition between an inpatient mental health setting and a community or care home setting is also involved.

## *4.2 Setting(s)*

### 4.2.1 Settings that will be covered

- Inpatient mental health settings:
  - All adult inpatient mental health settings (including low and medium secure services).
  - Specialist dementia units in adult mental health inpatient settings.
  - Tier 4 CAMHS inpatient settings.
  - Specialist units for people with mental health problems and additional needs such as learning disability, hearing impairment, eating disorders, and substance misuse.
- Care home settings
  - All residential or nursing care homes, including hospices.
- Community settings, including:
  - People's own homes and other housing, including temporary accommodation.
  - Extra care housing (such as warden-supported, sheltered or specialist accommodation).
  - Shared Lives Scheme (formerly Adult Placement Scheme) living arrangements.
  - Supported living.
- Police cells

### 4.2.2 Settings that will not be covered

- General inpatient hospital settings.
- Prison settings.
- High secure settings

## *4.3 Activities*

### 4.3.1 Key areas and issues that will be covered

All aspects of care planning and provision involved in supporting the transition between inpatient mental health settings and community or care home settings for children, young people and adults. The activities listed in this section apply (as appropriate) to both admission to and discharge from inpatient mental health settings.

a) Referral and assessment.

b) Care and support planning and review (including admission and discharge planning).

c) Self-directed support (including using a personal budget and based on a jointly agreed social care plan), self-help and support groups.

d) Co-ordination of care and joint working between mental health, social care and primary care. This will include service models of joint working and communication and information sharing.

e) Components of care packages that support effective and timely transitions between inpatient mental settings and community or care home setting. Examples include:

- crisis resolution and contingency planning
- assertive outreach
- advocacy
- information for people moving between settings and their carers
- social, emotional and practical support to help people live independently, this may include: occupational therapy, psychotherapy, cognitive behavioural therapy, counselling and peer support

- voluntary and community sector support, including individual mental health volunteers
- housing support to enable discharge from inpatient mental health settings (including repairs and adaptations)
- employment support.

f) Interventions and approaches to prevent or reduce readmissions to inpatient mental health settings, including crisis support and home treatment.

g) Support for carers of people moving between inpatient mental health settings and community or care home settings.

h) Learning and development for, and the support and supervision of, staff working with people moving between inpatient mental health settings and community or care home settings.

### 4.3.2 Areas and issues that will not be covered

a) Care and support planning that is not specifically designed to support timely transition between inpatient mental health settings and community or care home settings.

b) Admission avoidance.

c) Home care, unless it forms part of a care package intended to support a safe and timely transition. Where home care is covered in the guideline, the focus will be on its availability and organisation to ensure a timely discharge from inpatient mental health settings.

d) General inpatient hospital settings. The experience of adults with mental health difficulties, moving between general hospital settings and community or care homes will be covered in a separate NICE guideline (in development).

## *4.4 Main outcomes*

The main outcomes that will be considered when searching for and assessing the evidence include:

- experience, views and satisfaction of people in transition and their carers
- quality of life (including social care, mental health and health related outcome indicators)
- independence (people's ability to exercise choice and control in their lives, carry out daily activities)
- continuity of care
- suicide rates
- years of life saved.

Service outcomes include:

- use of mental health and social care services (community, primary and secondary care)
- need for formal care and support
- need for unpaid care and support
- length of hospital stay
- delayed transfers from inpatient mental health settings
- admission to residential or nursing care, including inappropriate admissions
- unplanned or inappropriate hospital admissions
- hospital readmissions

## *4.5 Review questions*

Review questions guide a systematic review of the literature. They address only the key issues covered in the scope and usually relate to interventions, service delivery or the experiences of people using services and their carers.

4.5.1 What are the views and experiences of people using services and their carers in relation to the transition between inpatient mental health settings and community or care home settings?

4.5.2 What are the views of health, social care and housing practitioners about the transition between inpatient mental health settings and community or care home settings?

4.5.3 How do different approaches to care planning and assessment affect the process of admission to inpatient mental health settings from community or care home settings?

4.5.4 What is the effectiveness of interventions and approaches designed to improve discharge from inpatient mental health settings?

4.5.5 What is the effectiveness of interventions and approaches designed to reduce or prevent re-admissions to inpatient mental health settings?

4.5.6 What is the impact of specific interventions to support people treated under the Mental Health Act during transition between inpatient mental health settings and community or care home settings?

4.5.7 What is the impact of specific interventions to support children and young people during transition between inpatient mental health settings and community or care home settings?

4.5.8 How should services support carers of people in transition between inpatient mental health settings and community or care home settings?

4.5.9 What impact does learning and development for mental health and social care staff have on transitions between inpatient mental health settings and community or care home settings?

These are only examples of areas that may be addressed. The review questions will be agreed by the Guideline Development Group (GDG) at the start of guideline development.

## *4.6 Economic aspects*

The guideline developers will take into account cost effectiveness when making recommendations involving a choice between alternative interventions or services. Appropriate economic review questions will be identified. A review of the economic evidence will be undertaken in line with the methods outlined in The social care guidance manual. Economic analysis, if undertaken, will consider all relevant commissioners, decision-makers, funders, providers, people using services and carers.

The analysis will be informed by evidence on service use, costs and outcomes from a broad range of studies. This may include international evidence. As far as possible, we will use sufficiently long time horizons to ensure we can explore long-term outcomes.

The analysis will use a public sector perspective (that is, costs and outcomes from the perspective of the health and social care system). However, a societal perspective may also be adopted to test the sensitivity of the results when including other relevant costs and outcomes related to people using services and their carers. This may include employment, housing and criminal justice outcomes.

## *4.7 Status of this document*

### 4.7.1 Scope

This is the consultation draft of the scope. The consultation dates are 30 September to 28 October 2014.

### 4.7.2 Timing

Guideline development will start in January 2015. The guideline is scheduled to be published in August 2016.

# 5 Related NICE guidance

## *5.1 Published NICE guidance*

- Managing medicines in care homes NICE social care guideline 1 (2014)
- Psychosis and schizophrenia in children and young people NICE clinical guideline 155 (2013)
- Patient experience in adult NHS services NICE clinical guideline 138 (2012)
- Improving the experience of care for people using adult NHS mental health services NICE clinical guideline 136 (2011)
- Rehabilitation after critical illness NICE clinical guideline 83 (2009)
- Occupational therapy and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care NICE public health guideline 16 (2008)
- Dementia NICE clinical guideline 42 (2006)

### 5.1.1 Other related NICE guidance

- Mental wellbeing of older people in care homes NICE quality standard 50 (2013)
- Quality standard for supporting people to live well with dementia NICE quality standard 30 (2013)
- Health and wellbeing of looked after children and young people NICE quality standard 31 (2013)
- Quality standard for supporting people to live well with dementia NICE quality standard 30 (2013)
- Service user experience in adult mental health NICE quality standard 14 (2011)
- Dementia NICE quality standard 1 (2010)

### *5.2 Guidance under development*

NICE is currently developing the following related guidance (details available from the NICE website):

- Home care NICE social care guideline, publication expected July 2015
- Social care of older people with multiple long-term conditions) NICE social care guideline, publication expected September 2015
- Transition between inpatient hospital settings and community of care home settings for adults with social care needs NICE social care guideline, publication expected November, 2015
- Older people: independence and mental wellbeing NICE public health guideline, publication expected September 2015
- Transition from children's to adult services NICE social care guideline, publication expected February 2016
- Mental health of people in prison NICE clinical guideline, publication expected November 2016

## 6 Further information

Information on the guideline development process is provided in the Social care guidance manual. Information on the progress of the guideline will also be available on the NICE website.

## 7 References

Byford et al (2010) Alternatives to standard acute in-patient care in England: readmissions, service use and cost after discharge. British Journal of Psychiatry 197: s20–s25

Gilburt H, Rose D, Slade M (2008) The importance of relationships in mental health care: a qualitative study of service users' experiences of psychiatric hospital admission in the UK. BMC Health Services Research 8: 1–12.

Lewis R, Glasby J (2006) Delayed discharge from mental health hospitals: results of an English postal survey. Health and Social Care in the Community, 14: 225–30

Longo S, Scior K (2004) In-patient psychiatric care for individuals with intellectual disabilities: the service users' and carers' perspectives. Journal of Mental Health 13: 211–21

Poole R, Pearsall A, Ryan T (2014) Delayed discharges in an urban in-patient mental health service in England. The Psychiatric Bulletin 38: 66–70

Sledge W, Lawless M, Sells D et al. (2011) Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations. Psychiatric Services 62: 541–4