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

Consultation on draft guideline
Stakeholder comments table

16 March 2016 – 27 April 2016

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Central and North West London NHS Foundation Trust (CNWL)	FULL	General	General	Reference to section 117 aftercare planning - really important that someone's s117 aftercare needs are clearly documented and identified as part of the care and support plan	Thank you for your comment. The Guideline Committee decided that the thorough assessment to support discharge (1.5.21) should 'cover aftercare support, in line with section 117 of the Mental Health Act 1983'.
Central and North West London NHS Foundation Trust (CNWL)	FULL	General	General	Whole document seems to expecting people to have longer admissions - needs to take account of people who are only in for a short amount of time - couple of hours to a few days potentially, the process of discharge planning as outlined in the document does not reflect sometimes the quick turnaround as soon as someone no longer needs acute inpatient care. Phased return to work or community activities is not realistic if someone no longer needs acute inpatient care but would be ok from a rehab unit.	Thank you for your comment. The Guideline Committee did consider the issue of how the guideline applies to people who are experiencing different lengths of stay and different types of admission (such as planned or unplanned. The decision was made to insert an introductory note explaining that recommendations should be applied at the soonest point after admission, irrespective of length of stay, if possible and if appropriate to the person's individual circumstances.
Central and North West London NHS Foundation Trust (CNWL)	FULL	General	General	Would be helpful to have a section on when individuals take their own discharge - planning at the point of admission section allows for plans starting but what happens if this planning is interrupted?	Thank you for your comment. Patients taking their own discharge is beyond the scope of this guideline. Furthermore, as the recommendations are based on the principles of collaborative and person-centred care a section on what to do when people take their own discharge would be contradictory.
Central and North West London NHS Foundation	FULL	General	General	It would be helpful to have potentially more guidance on the collaboration between inpatient and community services - are there circumstances when someone should always be referred to the community	Thank you for your comment. As the guideline is based on the principles of collaborative working the intention is to encourage

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Trust (CNWL)				team eg. detained on s3 etc for s117 aftercare. Clarifying the role of the CC eg. maintaining contact with someone once admitted (how frequently?)and taking the lead in identifying and supporting the wider community network and maintaining those relationships - the document could be read that it is all the inpatient services responsibilities.	interdisciplinary working and effective communication. See also the second implementation challenge on "ensuring effective communication between teams".
Central and North West London NHS Foundation Trust (CNWL)	FULL	General	General	The guideline is positive in terms of outlining developing coping strategies	Thank you for your comment and for your support for this aspect of the guideline.
Central and North West London NHS Foundation Trust (CNWL)	FULL	General	General	The guideline is positive in terms of outlining person centred and recovery focus	Thank you for your comment and for your support for this aspect of the guideline.
Central and North West London NHS Foundation Trust (CNWL)	FULL	General	General	The guideline is positive in terms of outlining supporting carers and maintaining social networks	Thank you for your comment and for your support for this aspect of the guideline.
Central and North West London NHS Foundation Trust (CNWL)	FULL	General	General	The guideline is positive in terms of outlining planning for discharge at point of admission	Thank you for your comment and for your support for this aspect of the guideline.
College of Mental Health Pharmacy (CMHP)		P16-7	Point 1.6.12-1.6.18	Despite this section being about discharge planning there is no reference to planning for the prescription of visit. No reference to planning to communicate with the GP. No reference to Medicines Reconciliation at transfer out/discharge. No reference to the NG5 again or to the planning required if a patient is on opiate - refer to the NPSA/2008/RRR005.	Thank you for your comment. The discharge planning section of the guideline has been reordered to address some of the issues which you and other stakeholders have commented on. All recommendations from 1.5 onwards refer to discharge planning and 'care planning to support discharge' is a

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					smaller subsection. Within this subsection 1.5.20 outlines 'details of medication' in the list of what the care plan should include. It now also cross references the NG5 Medicines Optimisation Guideline, specifically the recommendations in section 1.2 on medicines-related communication systems when people move from one care setting to another. Within the 'follow-up support' section there are recommendations around communication with the person's GP (see 1.6.2 and 1.6.3).
College of Mental Health Pharmacy (CMHP)		P18	1.6.20	Seems odd that a the section "On discharge" falls under the heading of "Follow-up support". These are separate things. It would flow better if you addressed issues for "On discharge" first, then had "Follow-up support" as a separate section.	Thank you for your comment. In light of your and other stakeholder comments the whole 'discharge planning' section (1.5) of the guideline has been reordered. 'Follow-up support' now sits in its own section and all issues to be addressed in the lead up to discharge are grouped together according to their theme.
College of Mental Health Pharmacy (CMHP)		P18	1.6.20	This is an issue of terminology. It is not usually a "Discharge summary" that is sent to the GP within 24. This is usually called a discharge "letter" or "notification". And the discharge summary usually means the much more detailed review document of several pages that the Dr writes a few days later. Given the issues with this terminology you need to specify what document you mean. Additionally it may be helpful to add this to your list of definitions of terms. Please do specify that the document you want to be sent to the GP within 24 hour (in line with NICE NG5) specifies the details of the exact current prescription, the reasons for any changes in medicines, and the immediate medication treatment plan (ie should the GP continue supplying these medicines? Should they increase or decrease the dose? When will it be reviewed and by whom?)	Thank you for your comment. We discussed your point with the GC and they agreed that the recommendation (now 1.6.3) should be amended to include the term 'discharge letter' as the document which is sent to the GP within 24 hours. 'Discharge letter' has also been defined in the 'terms used in this guideline' section to clarify that this is a short document containing information on prescriptions and medications. The third bullet point states that within a week a 'discharge summary' should be sent to the GP and others agreed in the care plan. Discharge summary has been included in the 'terms used in this guideline' to highlight this is a more detailed review document which includes information about why the person was admitted and how their condition changed during their hospital stay.

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College of Mental Health Pharmacy (CMHP)		P20-21	1.6.25 - 27	In this section on "Community **treatment** orders" you have not made any mention of telling the patient about the actual treatment that will be provided! Please add in that the patient and families/carers etc should be informed of the treatment plans and have an opportunity to discuss this (as well as the restrictions and review period).	Thank you for your comment. The Guideline Committee was confident that the person's actual treatment was covered by the points already stated in the recommendations on Community Treatment Orders. As the evidence showed that there is often a lack of clarity around how Community Treatment Orders work and why they are imposed the GC wanted to highlight the importance of explaining the details of their purpose as well as giving consideration to the particular benefit it might hold for that person. 1.6.10 gives the example of how practitioners might talk through the CTO's purpose in terms of how it supports the treatment plan. 1.6.12 specifies that the CTO should be discussed with the carer. One of the overarching principles (1.1.5) states that practitioners should explore ways in which the people who support them can be involved throughout their admission and discharge.
College of Mental Health Pharmacy (CMHP)		P6	Point 1.2.7	Need to add some reference in here to the essential requirement for doing full medicines reconciliation within 24 hours of admission (NG5 point 1.3.1).	Thank you for your comment. 'Current medication' has now been added to this point. Also, 1.2.7 now cross references the medicines reconciliation section of the Medicines optimisation guideline (NG5).
College of Mental Health Pharmacy (CMHP)		P7	Point 1.3	Again need to link to NG5 and the activity of medicines reconciliation.	Thank you for your comment. 1.2.7 now cross references the medicines reconciliation section and 1.5.20 cross references the recommendations on medicines-related communication systems when people move between care settings of NICE's Medicines Optimisation guideline.
College of Mental Health Pharmacy (CMHP)		P7	Point 1.3	Nothing in here about the importance about effective communication about the patients intended treatment plan between healthcare providers. Given the emphasis on this in the Francis report, this needs adding in. Additionally need to mention to avoid "double scripting" of abusable medicines, notably	Thank you for your comment. Ensuring effective communication between teams is one of the implementation challenges set out in the guideline, see the second implementation challenge "Ensuring communication between teams, and with

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				opiates – refer to the NAPSA alert: NPSA/2008/RRR005.	people using services and their families and carers." In particular, the challenge draws attention to the need for practitioners to work together across physical and professional boundaries as well as the need for good communication between health and social care practitioners working in multidisciplinary teams. 1.2.7 now cross references the medicines reconciliation section. 1.2.8 recommends that if more than one team is involved in a person's transition to, within and from a service, there should be ongoing communication between those teams. Ensuring effective communication between health and social care practitioners working in multidisciplinary teams is one of the implementation challenges set out in the guideline. And 1.5.20 cross references the recommendations on medicines-related communication systems when people move between care settings of NICE's Medicines Optimisation guideline.
College of Mental Health Pharmacy (CMHP)		P8	Point 1.3	Nothing included here about multidisciplinary team working. Given the emphasis of this in order to deliver effective care by the Francis report this needs adding in before you say that discharge needs to be planned.	Thank you for your comment. 1.2.8 recommends that if more than one team is involved in a person's transition to, within and from a service, there should be ongoing communication between those teams. Ensuring effective communication between health and social care practitioners working in multidisciplinary teams is one of the implementation challenges set out in the guideline.
College of Mental Health Pharmacy (CMHP)	Short version	General		Guidance is surprising generic and non specific. Disappointed at the lack of reference to medication given that this is the most common treatment for patients admitted to MH services (>99%). Details need adding to be meaningful.	Thank you for your comment and feedback. The Guideline Committee discussed your comment and the following changes concerning medication have been made to the recommendations: 1.2.7 about recording details of the person's current medication during admission planning now cross references the medicines reconciliation section of NICE's medicines optimisation guideline. 1.5.20 about the care plan cross references the

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					'medicines-related communication systems' in the medicines optimisation guideline). 1.6.5 about discharging someone to a care home cross references the 'Sharing information about a resident's medicines' in NICE's Managing medicines in care homes guideline.
College of Mental Health Pharmacy (CMHP)	Short version	General		Also surprisingly little cross reference to other NICE guidance (eg no reference to the Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes NICE guidelines [NG5] March 2015) or relevant NPSA alerts. Such details need adding.	Thank you for your comment. NICE's Medicines Optimisation guideline is now cross referenced in 1.2.7 and 1.5.20. In both cases the cross reference is linked to a specific section of the guideline. The recommendation on recording the person's current medication during admission planning links to the section on medicines reconciliation. The recommendation on what to include in the care plan links to the section on medicines-related communication systems when patients move from one care setting to another.
Department of Health	Short	General	General	I read the short version recommendations - had a general comment that it could reference the Mental health Act 1983 Code of Practice which provides guidance on pre-admission, admission and discharge which providers should comply with. At 1.3.13 as well as the issues mentions for discussion with the patient it would be useful if it also includes discussions about their treatment, setting goals for recovery and discussions where appropriate about working towards discharge and indicating likely length of stay in hospital where possible and appropriate. At paragraph 6 on Planning Support – again it would be good if they could include involving and co-producing care plans with patients	Thank you for your comment. The Mental Health Act Code of Practice which was last revised in 2015 is referenced in the context section of the full guideline. 1.3.19 addresses a specific task of addressing any physical healthcare, mental health treatment, or addiction issues that may need immediately addressing on admission in order to address personal needs. Discussions about treatment and setting goals for recovery are covered elsewhere in the guideline (for example in 1.2.9, 1.3.1, 1.5.17) The guideline was careful to highlight the importance of involving service users in planning their care, recommendation 1.1.2 in the Overarching Principles section addresses this issue.
Kirklees Council – Public Health	Full	14	General	This related to Section 1.6 – Discharge from hospital. I think that you need to make it clear that questions should be asked about a persons accommodation upon admittance to hospital – that the discharge planning needs to take place as soon as possible	Thank you for your comment. 'Accommodation' now appears as a subsection of section 1.5. There are 2 recommendations within this – one about ensuring that the accommodation someone

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				upon admission or before if the stay is planned. I think this should actually be within the Admissions section. I also think you need to make it clear that healthcare staff from within the hospital need to be making close links with Housing and social care staff (as appropriate) as part of this process – rather than just family/carers.	is being discharged to is suitable for them (1.5.7), and another about giving people who are homeless, or at risk of homelessness, structured support to find and keep accommodation (1.5.8). Both of these recommendations state that they should happen before discharge. In the 'Before hospital admission' section (1.2) there are two recommendations highlighting that healthcare staff should forge links with housing support practitioners. 1.2.1 states that mental health and primary care practitioners should respond to requests of assessment of mental health from hostel or housing and community support workers, while 1.2.2 is about involving community accommodation and community support workers in any planned admission.
Kirklees Council – Public Health	Full	General	General	It looks like a good strategy on paper but in reality feels a long way off and concern was how it would be implemented. For example the best practice around having people who could be detained having opportunity to look around inpatient units before section, how would this be resourced and managed?	Thank you for your comment. We understand your concerns about how the guideline will be implemented. The NCCSC will be producing a plan to support NICE on implementation and they would welcome further input from your organisation to help us consider challenges such as that which you describe. In the meantime, on the specific issue you raise, the guideline committee came to the view that while this is, indeed, best practice it is easier to make arrangements for planned admissions (see 1.2.5). They also added (at 1.2.6) 'If it is not possible for the person to visit the inpatient unit they will be admitted to in advance, consider using accessible online and printed information to support discussion about their admission.' The committee did not consider the resource impact to be significant for this and, as highlighted in 1.2.5, wished to signal its particular importance for a number of population groups.
London Borough of Newham	Short version	15-16	1.6.7. – 1.6.9	Firstly, who might the designated professional be? A recovery plan could be an extremely useful tool for someone, but it would need to be completed by someone with an understanding of social care needs and outcomes as well as their health ones. Secondly, how might this recovery plan overlap and /	Thank you for your comment. In light of your and other stakeholder comments the Guideline Committee discussed care and recovery planning and the various related documents which are referenced in the recommendations at length.

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				or interact with other crucial documents that might contain details of peoples' care and support arrangements? For example, how might the Recovery Plan relate to the CPA Care Plan; a social care Support Plan; a Crisis Plan; or a care home Support Plan? For customers with a great deal of input from different agencies there could be a confusing confluence of person-centred documents that partially or substantially replicate each other. This might serve to confuse patients, rather than give them the tools they need to enhance their ability to administer self-care.	The committee did not feel that it was possible to stipulate in any more detail who the 'designated professional' should be. There is too much variance in practice to be able to make a meaningful suggestion, and the point of the recommendation is to make sure that there is one person who is accountable for writing the plan in collaboration with the person. However, they did agree that the guideline would benefit from more clarity around the documents which are referenced. It was decided that to avoid confusion around terminology the recommendations would not reference a recovery plan *per se* but use only the term 'care plan'. As outlined in 1.5.17 the care plan is based on the principles of recovery. The committee also wanted to avoid making specific reference to the Care Programme Approach where possible, as they wanted to make sure that the recommendations would maintain as broad a remit as possible.
London Borough of Newham	Short version	17	1.6.16.	It might be appropriate to add into this point that practitioners may also need to be mindful of whether - or which of - the patient's needs will be met under Section 117 Aftercare arrangements.	Thank you for your comment. The Guideline Committee agreed with your suggestion that the assessment should cover aftercare support, and 1.5.21 now includes a bullet about covering aftercare support in line with section 117 of the Mental Health Act 1983.
London Borough of Newham	Short version	18	1.6.20.	GPs should perhaps be involved in discharge planning in more active way (and earlier on in the process,) particularly if someone is going to be treated in a primary care setting upon discharge. An email to a GP may not sufficiently allow the primary care practitioner to plan the support and treatment that the patient might require, or give them adequate time to raise concerns about the ability of primary care to meet the customer's needs if there is a different of opinion. This could be crucial to avoiding readmissions for customers being discharged.	Thank you for your comment. The recommendations reinforce the importance of joint working and effective communication between inpatient and community teams (including primary care practitioners and specialist services). For example, 1.1.7 highlights the need for mental health services to work with primary care and local third sector organisations to ensure that people in transitions have equality of access to services.
London Borough of	Short version	20	1.6.26	Perhaps it could also be included that this would be an appropriate time to refer customers to an	Thank you for your comment. The Guideline Committee were very supportive of your

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Newham				Independent Mental Health Advocacy Service. IMHA services are required to work with customers who are subject to community treatment and guardianship orders, and an advocate might give the patient more confidence to be able to discuss and challenge the conditions being applied. This could serve to improve practice and ensure that the patient's voice is heard.	suggestion and this recommendation (1.6.11) now includes the bullet 'how to access advocacy (including their entitlement to an Independent Mental Health Advocate), and what this means'.
London Borough of Newham	Short version	5-6	1.2.1.	We know that this reflects the wishes of providers of supported living services (care homes) within the market who feel they are uniquely placed to identify mental health crisis and / or relapse at the earliest opportunity. However, prioritisation of referrals from certain sources would need to be balanced against AMHP Services' need to respond appropriately to the needs and risks of *all* individuals who have been referred for a mental health act assessment, regardless of the referral source. Will more specific guidance be issued as to how this can be achieved?	Thank you for your comment. 1.2.1 is derived from moderate quality qualitative evidence that carers of people who were formally admitted felt unable to get help until that person's illness led to sectioning; and from good and moderate quality evidence that people with learning disabilities admitted to mainstream mental health units experienced great difficulty in accessing mental health assessment and care. The intention of the recommendation is not to say that these requests should be prioritised over those from any other sources, but rather to highlight that requests from these sources, (which the evidence has shown to be ignored in practice) should not be overlooked.
London Borough of Newham	Short version	6	1.2.7.	The recognition of peoples' physical health needs as well as their mental health needs during admission is a welcome principle. However, does this wording go far enough in terms of promoting parity of esteem between physical health and mental health?	Thank you for your comment and support for this recommendation. The Guideline Committee felt that as the wording of 1.2.7 already included physical health that this parity was being promoted.
London Borough of Newham	Short version	7	1.3.1.	At present, the provision of Independent Mental Health Advocacy is only a statutory requirement for people detained in hospital under certain sections of the MHA. The provision of advocacy services for informal patients is an important principle but it may not be provided unilaterally unless the responsibility for commissioning these services is clarified, and funding made available.	Thank you for bringing this to our attention. 1.3.4 recommends that access to advocacy services is 'offered' to everyone. The recommendations are intended to be aspirational and promote best practice. Note that 1.3.4 does not use 'must' which would signify that it is a legal requirement. Under the 'Community treatment orders' section 1.6.11 has a recommendation for people subject to the Mental Health Act with stronger wording: 'explain how to access advocacy (including their entitlement to an Independent Mental Health Advocate), and what this means.'
London	Short	8	1.3.5.	There is full agreement that discharge planning	Thank you for your comment.

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Borough of Newham	version			should start at the point of admission. However, what this entails isn't always clear. If referrals to services are required, it is always better that these are made early, particularly if a carer's (re)assessment is required; or a supported living / residential care placement is considered necessary. Moreover, there should be an early identification of whether or not a customer is (or is going to be) subject to Section 117 Aftercare. This means that any discussion about joint funding between health and social care services can begin early, and transfers of care can be planned.	The Guideline Committee discussed how the recommendations are intended to cover both planned and unplanned admissions and how the timing of planning around these different kinds of admission will inevitably differ. It was decided that an introductory note should be inserted to the start of the guideline to explain that in the case of planned admissions, pre-admission planning is recommended wherever possible, and for unplanned admissions recommendations should be applied at the soonest point possible after admission, if possible and appropriate to the person's situation.
London Borough of Newham	Short version	9-10	1.3.13.	Again, could this guidance go further in promoting parity of esteem? Could this include identifying and raising risks to patients' long-term health as well as the treatment required for their immediate health needs? For example, it would be a positive step if the senior healthcare professional talked to customers about the risks of drinking alcohol; high blood pressure; smoking; and lifestyle factors that could impact on their long-term health, and making information and support available to those who wish to make changes. It might also be appropriate to engage patients in conversations about their sexual health, and offer them information about different forms of contraception; particularly for women who are sexually active and for whom long-acting reversible contraception might be of benefit.	Thank you for your comment. The GC considered your suggestion and decided to add a bullet point 'pregnancy, breastfeeding or the need for emergency contraception' to 1.3.19. Another point about ensuring the care plan for recovery includes information on: 'physical health needs including health promotion and information about contraception' (1.5.20) was also added.
Member of the public (not org)	Express Newspapers article	general	general	With reference to the recent Express Newspaper article (18 March 2016, NICE propose guidelines to reduce suicide risk after hospital stay), I am writing to support the view that suicides can be drastically reduced if everyone in medical care adopt the existing guidelines as policies. Simplifying the guidelines into the following 2 key points would most certainly help but only if everyone in the care profession adopt them as policies. • Unless there are good reasons not to, family and friends must be informed and briefed on how to	Thank you for your comments and for your detailed response to the guideline. The Guideline Committee also agreed that the value of involving the person's family and carers in their recovery post-discharge could not be overestimated. In order to emphasise the importance of involving families and carers when there is the possibility of self-harm or suicide the following bullet was added to 1.3.12 about what planning for treatment after discharge should involve:

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				help where there is the slightest possibility of self harm or suicide. • Unless there are good reasons not to, active monitoring and sharing of information with all concerned should be put in place where there is the slightest possibility of suicide until the risk has subsided. Your Professor Gillian Leng stated that involving family and friends have helped prevent suicides. Studies across the world concur. Yet, this is not adopted as a policy by the vast majority in NHS England.	• Discussing with the person's family carer how to support them to stay safe. One of the overarching principles of the guideline is about identifying the person's support networks (1.1.5). It recommends working with the person to explore ways in which the people who support them can be involved throughout their admission and discharge. We also hope that the guideline can help to combat complacency around suicide by informing best practice. New recommendations have been added at 1.6.7 and 1.6.8 to conflate discharge planning and assessment of risk. Details of guideline committee minutes and deliberations can be found in the documents that accompanied the development of this guideline on the NICE website. The LETR tables found in the long version of the guideline also describe how recommendations were formulated.
Mental Health Nurse Academics UK	LONG	11	24,25	The CPA is not a UK wide system as stated here. It is used in England and Scotland, and Wales now has Care and Treatment Plans as legislated for in the Mental Health (Wales) Measure. In Northern Ireland a universal assessment is used.	Thank you for your comment. This reference to the CPA has now been amended to reflect your point about the system only being used in England and Wales as opposed to being UK-wide.
Mental Health Nurse Academics UK	LONG	12	1	For clarity the National Service Framework for Mental Health applied to England only and reference to national strategies in the document more generally need to be clear that these apply in only one part of the UK.	Thank you for your comment. This sentence now reflects that the National Service Framework applied only to England. 'No health without mental health' is now described as 'the mental health strategy' and not 'the national mental health strategy'.
Mental Health Nurse Academics UK	LONG	15	22 onwards 'Before hospital admission'	We agree that timely, coordinated, responses to people in crisis are essential. Guidance should emphasise the importance of effective communication across parts of the care system (primary care, CMHTs, CRHTTs) to prevent service users having to repeat information as they move through.	Thank you for your comment. Throughout the development of the guidance the Guideline Committee were mindful that while medical histories are valuable, having to repeat information time and time again is potentially unsettling and

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					stressful for the person undergoing transition. As a result recommendation 1.2.1 has been amended to state that assessments for people in crisis should be prioritised and 1.2.7 has been worded: 'During admission planning, record a full history or update […]'. Communication across parts of the care system is also the focus of rec 1.2.8 which recommends that when more than one team is involved in someone's admission there should be ongoing communication between those teams. 'Ensuring effective communication between teams, and with people using services and their families and carers' is one of the implementation challenges for this guideline (see section titled 'Implementation: getting started'). It states that practitioners need to work together across physical and professional boundaries and highlights that commissioners and managers need to ensure that effective systems are in place to help practitioners to communicate effectively.
Mental Health Nurse Academics UK		17	19 onwards 'Hospital admission'	In Wales, advocacy is now extended (under the Measure referred to in 1 above) to all inpatients.	Thank you for your comment and for informing us of this update. 1.3.4 recommends that all people should be offered access to advocacy services on admission which reflects Wales' extension of advocacy to all inpatients.
Mental Health Nurse Academics UK		18	4	Recent NIHR HSDR research confirms that service users in the community place particular value on the quality of their relationships with practitioners [Simpson et al 2016, http://www.journalslibrary.nihr.ac.uk/hsdr/volume-4/issue-5#abstract]. Ongoing NIHR HSDR research confirms that this is also the case with services users who are inpatients [Simpson et al, ongoing: http://www.nets.nihr.ac.uk/projects/hsdr/131075]	Thank you for your comment and for passing on links to current and ongoing research on this topic. However, as there is no explicit mention of transitions in this research it would not have met the inclusion criteria for our evidence review for this guideline. The NIHR study was not published during the guideline development but may be considered when the guideline is updated in 2018, if it meets the inclusion criteria,

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Mental Health Nurse Academics UK		23	18 onwards 'During hospital stay'	A recent NIHR evidence synthesis highlights the risks to young people in mental health hospital of losing touch with friends, family and education and of stigma, threats to identity and normal life [Hannigan et al, http://www.journalslibrary.nihr.ac.uk/hsdr/volume-3/issue-22#abstract]	Thank you for your comment and for passing on links to current and ongoing research on this topic as well as your support for this section of the guideline.
Mental Health Nurse Academics UK		23	6	Reference to care programme approach meetings should read 'care planning meetings' to acknowledge that CPA is not UK wide, 'care planning' is a more generic description for this purpose	Thank you for your comment. The GC agreed that Care Programme Approach meetings should be amended to care planning meetings as not everybody will be on CPA and this allows for a broader approach.
Mental Health Nurse Academics UK		24	19 'Discharge from hospital'	Guidance in the area of planned discharge is important, but emerging evidence [Simpson et al, ongoing: http://www.nets.nihr.ac.uk/projects/hsdr/131075] is of service users facing either hasty discharge (as beds are needed for others) or delayed transfers (as accommodation is awaited). Our view is that both are unsatisfactory. MHNAUK members also say that discharge from secondary mental health services needs to be better planned and marked, as a step on the route to recovery.	Thank you for your comment and for bringing our attention to emerging evidence on care planning surrounding discharge. The guidance provides recommendations with a view to avoiding both rushed discharge (see 1.5.1 about ensuring discharge is 'suitably paced so the person does not feel their discharge is sudden or premature') and delayed transfers (it is recommended in 1.3.7 that discharge planning starts at admission and that there is a regular review of progress towards discharge). In 2018 the guideline will be reviewed for updating, If it is decided to update the guideline this evidence may be considered (if it meets the inclusion criteria)
Mental Health Nurse Academics UK		24	9 onwards Education	As per comment 6 above.	Thank you for your comment and for passing on links to current and ongoing research on this topic as well as your support for this section of the guideline..
Mental Health Nurse Academics UK		26	8 onwards 'Recovery plan…'	Recent NIHR HSDR research suggests that care plans are not actively valued or used by service users, and present as an administrative burden to practitioners [Simpson et al 2016, http://www.journalslibrary.nihr.ac.uk/hsdr/volume-4/issue-5#abstract].	Thank you for your comment. The study you have provided a link for does not refer specifically to inpatient mental health hospital to community transitions and as such it would not have met the inclusion criteria for this review. Our review specifically looked at the best available evidence relating to transitions and recommendations were made accordingly.

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					The section on 'Care planning to support discharge' within the guideline contains best practice recommendations on how to create and use a care plan in a way that *is* most beneficial to all parties. This includes making sure that service users do use and value them and that practitioners review them and use them properly too.
Mental Health Nurse Academics UK		31	9 onwards	Research recommendations could include generating new knowledge on how practitioners should and could engage people in discussions about their risk status given that the transition point is so critical to risk outcomes. Recent research has shown that in general workers don't discuss or share risk assessments with people and that service users themselves see benefits of being involved in understanding and managing their own safety e.g. [Simpson et al 2016, http://www.journalslibrary.nihr.ac.uk/hsdr/volume-4/issue-5#abstract]. Studies that trial interventions and measure outcomes for individuals involved in discussions of risk and contributing to management plans for risk are thin on the ground (Farrelly et al) and more knowledge is required to establish evidence based ways of conducting this important work.	Thank you for your suggestion. We acknowledge that risk-management relating to hospital transitions is an important area of research.. The Guideline Committee can only make research recommendations in response to gaps in evidence that have been identified through the evidence review. Research recommendations were prioritised by the committee using a systematic approach.
Mental Health Nurse Academics UK	As above	11	24 onwards	Care and treatment planning and care coordination are now on a statutory footing in Wales following the passing of the Mental Health (Wales) Measure referred to in comment 1 above.	Thank you for your comment. NICE guidelines cover health and care in England. Decisions on how they apply in other UK countries are made by ministers in the Welsh Government, Scottish Government, and Northern Ireland Executive. As such it is not appropriate to make an explicit reference to the Mental Health (Wales) Measure 2010 here.
Mental Health Nurse Academics UK	Full	10	General	We appreciate that NICE guidelines are primarily directed at health and social care services in England. However, under a service level agreement NICE guidelines, as we understand it, are also made explicit use of in Wales. Therefore, this section could be	Thank you for your comment. NICE guidelines cover health and care in England. Decisions on how they apply in other UK countries are made by ministers in the Welsh Government, Scottish

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				amended to incorporate reference to the Mental Health (Wales) Measure 2010, which has specific parts directed at care planning and coordination and provision of care in hospitals [http://www.legislation.gov.uk/mwa/2010/7/contents]	Government, and Northern Ireland Executive. As such it is not appropriate to make an explicit reference to the Mental Health (Wales) Measure 2010 here.
Mind	Full	16	3	It would be helpful to include in the list of people with complex needs, people with multiple needs and exclusions – thinking particularly of mental health, substance misuse, homelessness and criminal justice system contact. A coordinated response is especially important to people in these circumstances (see Making Every Adult Matter - http://meam.org.uk/) and discharge is a key point at which support needs to be mobilised.	Thank you for your comment. We appreciate your wish to see all potentially relevant groups listed under this recommendation, however as a general principle any lists given on NICE guidelines are not intended to be exhaustive. Furthermore, the examples given under this recommendation are specifically derived from evidence given by expert witnesses during the review process. The Guideline Committee felt it was important that particular attention was given to these groups, but that the wording for the opening sentence was kept broad in order to cover other vulnerable groups such as the ones you have mentioned.
Mind	Full	18	17	Advance decisions should be followed (subject to restrictions in the Mental Capacity Act and Mental Health Act), not just taken into account.	Thank you for your comment. The Guideline Committee agreed that advance directives should be given more precedence. In line with your comment the group felt that advance directives should be referred to in a separate recommendation, and that the wording should emphasise action (rather than just taking them into account). As such 1.3.3 now states that advance decisions must be followed in line with the Mental Capacity Act.
Mind	Full	19	14	This section on information about legal status and restrictions should include information about advocacy and how to raise concerns	Thank you for your comment. Within the section on legal status 1.3.14 recommends that a senior health professional should ensure that they know they have the right to appeal, and that information and advocacy can be provided to support them to do so if they wish.
Mind	Full	21	2	Women have told us how important it is to them not be under observation by male staff. It would be helpful to address gender directly in this section, not only	Thank you for comment. The GC felt it was too prescriptive to recommend that

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				indirectly with reference to privacy and dignity.	female inpatients should not be under observation by any male members of staff. However, the committee understood your point to be about making an effort to understand personal preferences and upholding people's dignity and safety during the process. 1.3.15 now includes the following amended point: 'explain how they will be observed and how often (taking account of personal, gender and cultural preferences)'.
Mind	Full	26	12	It may be helpful to differentiate the crisis/contingency elements of the recovery plan, so that it is clear that the plan covers both the support to be provided on discharge and on and ongoing basis, and also what will happen if the person's mental health deteriorates. It is good that crisis planning is seen as integral to care planning and important that both aspects are covered, but they are different.	Thank you for your comment. The Guideline Committee discussed care and recovery planning at length on account of your and other stakeholder comments. It was decided that to avoid confusion around terminology the recommendations would not reference a recovery plan *per se* but use only the term 'care plan'. As outlined in 1.5.17 the care plan is based on the principles of recovery. The revised recommendations make it clear that the care plan should describe support arrangements for the person after they are discharged as well as containing details of where to go in a crisis (1.5.20), while there are other recommendations about the importance of crisis planning for those who have had more than one admission (1.2.9)
Mind	Full	30	19	Community treatment orders – this section sits oddly with the rest of the guideline given that other decisions to admit or discharge informally or under the Act are not discussed in this way. It may be read as implicit support for or advocacy of the use of CTOs rather than guidance when they are being used. This is concerning given the OCTET findings and the restrictive nature of CTOs.	Thank you for your comment. The Guideline Committee were cautious when making recommendations on CTOs. The committee understood their restrictive nature and that too often in practice they are given without necessary thought. The best available evidence revealed that: they are not effective in reducing readmission; understanding of how CTOs work in practice varies considerably; and psychiatrists' examples of when CTOs had been beneficial was very dependent on the type of patient. Using this evidence the Guideline Committee made recommendations 1.6.10-1.6.12 which are intended to prevent bad practice around the implementation of

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					CTOs.
Mind	Full	31	4	However it is helpful to emphasise that not following the conditions does not automatically lead to recall.	Thank you for your comment. The guideline committee wanted to emphasise that not contravening conditions did not automatically lead to recall as the evidence showed that this was a commonly misunderstood aspect of CTOs. The recommendations relevant to CTOs are 1,6,9, 1,6,10 and 1,6,11.
Mind	Full	31	6	The patient needs to be informed of the legal basis of the order (not only carers), informed of their right to advocacy, and supported to access it.	Thank you for your comment. The guideline committee agreed with your comment and added 'how to access advocacy (including their entitlement to an Independent Mental Health Advocate) and what this means' as a bullet on 1.6.11. The committee were satisfied that the last bullet 'what will happen if the person does not comply with the order […]' sufficiently covered informing the person of the CTO's conditions and legal basis.
Mind	Short/Full	General	General	We welcome this draft guideline. It addresses very important aspects of mental health care, which affect people's well-being, recovery and safety. Healthwatch England's inquiry report *Safely home* shows how poor people's experience of discharge can be and the impact of this.	Thank you for your comment and support for the guideline. We hope that the guideline will help to improve people's experience of discharge from mental health inpatient settings, and that it will reduce adverse outcomes resulting from poor transitions.
Mind	Short/Full	General	General	We particularly welcome the clarity and specificity of who needs to be involved in planning care at transition points, inclusion of peer support, the strong emphasis on keeping people connected with their lives and/or phased reintroduction, and the attention on a thorough assessment of needs on discharge (including exploration of personal budgets).	Many thanks for your comment and support for these aspects of the guideline.
Mind	Short/Full	General	General	Impact/challenge – implementation of the whole guideline is challenged by the pressures on acute mental health services, both the under-funding and under-staffing of community teams and high demand on inpatient beds. These issues are well-described in the *Five Year Forward View for Mental Health* and the Independent Commission on Acute Adult Psychiatric Care's *Old problems, new solutions*. The good planning and preparation for both admission and discharge which the guideline describes are	Thank you for your comment. We are very conscious of the challenging context for this guideline. NICE do intend that commissioners of mental health services should take account of this guideline in specifying for services and will be taking account of this point in our stakeholder engagement and communications planning for publication and beyond as well as our discussions with NCCSC about implementation support.

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				compromised by these pressures which require solutions at the level of commissioning as well as local practice.	
Mind	Short/Full	General	General	Impact/challenge – the *Five Year Forward View for Mental Health* and *Old problems, new solutions* clearly shows the importance of suitable housing in enabling safe and timely discharge. Social care is also critical. Housing and social care provision are under extreme pressure and both will be essential for the relevant recommendations to be implemented.	Thank you for your comment. We agree that evidence that informed this guideline suggests practitioners in social care, housing and the NHS as well as the community, voluntary and independent sector will need to work together to ensure care and support of people in transition is person-centred and focused on their recovery. The link to housing services has been strengthened in this guideline with the recommendations relating to accommodation in discharge planning (recs 1.5.7 and 1.5.8)
Mind	Short/Full	General	General	There are numerous indications of differential experience/treatment of some minority ethnic groups in acute mental health care. The *Five Year Forward View for Mental Health* states that men of African and Caribbean heritage are up to 6.6 times more likely to be admitted or detained under the Mental Health Act, and it describes this as a systemic failure in crisis care for these groups. The economic evaluation of joint crisis plans found improved outcomes and lower costs for people of black ethnicity (p.260, table). Information Mind collected from mental health trusts in 2012 was consistent with the literature suggesting that people from some black and minority ethnic groups tend to come into mental health services later and more unwell. A 2010 report by Social Action for Health, *Hear I am*, highlighted dynamics between staff and patients, particularly African Caribbean men, on a London ward. The men tended to stay longer and be less included in ward life. The recommendations in this guideline should be beneficial to people from BME groups, as to all communities. However, given the disparities and barriers above, it would be helpful if the guideline advocated a more proactive approach to BME groups for example through tailored advocacy and tailored peer support. (See the Side by Side project -	Thank you for your comment. The Guideline Committee were mindful of the differential treatment of some minority ethnic groups in acute mental health care throughout the development of the guideline. In particular, the committee felt it was important to ensure that advocacy services offered on admission to hospital should take into account the person's cultural and social needs (1.3.4). 1.3.15 in 'Observations and restrictions' also states that the manner in which observations take place should take account of personal, gender and cultural preferences. As you point out an economic evaluation of joint crisis plans found improved outcomes and lower costs for people of black ethnicity. Although, the committee wanted to highlight joint crisis plans' increased cost-effectiveness for black (African and Caribbean) people, they felt that they could not specify this group at the exclusion of all others, as the benefit of crisis plans is well established across all ethnic groups, hence the wider recommendation. The Guideline Committee reflected that the research recommendations on Peer Support and Children and Young People in Transition between settings should both include the question "Is there any particular

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				http://www.mind.org.uk/get-involved/peer-support/peer-support-programme/?ctaId=/get-involved/peer-support/slices/side-by-side-improving-mental-health-through-peer-support/)	benefit for black, Asian and minority ethnic communities?"
National Housing Federation	Full version	general	general	**Potential evidence on supported housing and mental health includes:** **Specialist housing support for people with mental health needs (limited evidence, 1+, cost effective)** There have been specific evaluations of different forms of supported accommodation as one crucial element in a pathway of care for people with mental health needs. It has the potential to be highly cost effective, for instance if it can help reduce both the need for inpatient care and the chances of individuals becoming homeless or falling into substance abuse. There have been several large scale well-designed evaluations of these programmes in North America and also in France. At Home/Chez Toi is a Canadian version of 'Housing First', an approach developed in the US that provides immediate access to housing without any preconditions. This programme integrates housing and support services. It offers people a choice of housing, where they want to live and goals they want to achieve. This may include help in getting integrated into their local community or getting a job. The programme has been shown to be cost effective with the general homeless population in the US. Early analysis in the Canadian study suggests a substantial reduction in health, social care and justice system costs for those tenants who previously had been high service users before the study. There was an annual reduction in costs to the government of $Can 9,390 per person per year[1]. This represents a saving of $	Thank you for your comment. The scope of the guideline looks at housing indirectly in that the recommendations take account of accommodation needs on discharge (recs 1.5.7 and 1.5.8), but there is no explicit focus on housing and therefore the types of evidence and research that you mention do not fall within the scope of the guideline. The scope of the guideline only includes the role of practitioners in health and social care through roles such as advocacy or coordination to link up with housing support professionals. We did not look at the different types of housing support. This is not within the remit of NICE health and social care guidelines. When we searched the literature on interventions that help reduce readmissions and support discharge, we did come across some evaluations where professionals were meant to improve continuity of care or links to appropriate services. This would have included professionals making referrals or contacting housing support services or professionals.

[1] Mental Health Commission of Canada. Beyond housing. At Home/Chez Toi Early Findings Report. 2012 Volume 3. Available at http://www.mentalhealthcommission.ca/English/system/files/private/document/Housing_At_Home_Early_Findings_Report_Volume_3_ENG.pdf

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				Can 1.54 for every $ Can 1 invested in At Home/Chez Toi. A recent paper looking solely at the results of At Home/Chez Toi in Vancouver after the first year of the study has also reported significantly lower rates of emergency health care services in the Housing First group compared to existing social welfare services and support[2]. A non-randomised small study in the US looking at the use of Housing First for homeless people with alcohol problems also found a reduction in contact with hospital accident and emergency departments, less use of alcohol treatment centres and reduced time in custody. Total benefits were between two and three times greater than the cost of the programme[3]. While this evidence is strong, there has however been very little robust evaluation in the UK on effectiveness and cost effectiveness, although work is being undertaken, including a new study funded by the UK National Institute for Health Research to look at quality, effectiveness and cost effectiveness of supported accommodation services (including floating support)[4]. Instead most of the economic analysis in England has focused on more traditional forms of accommodation support. A few case studies with very small samples[5] were prepared by the Department of Health in England[6],	

[2] Russolillo A, Patterson M, McCandless L, Moniruzzaman A, Somers J. Emergency department utilisation among formerly homeless adults with mental disorders after one year of Housing First interventions: a randomised controlled trial. International Journal of Housing Policy 2014; 14(1):79-97.

[3] Srebnik D, Connor T, Sylla L. A pilot study of the impact of housing first-supported housing for intensive users of medical hospitalization and sobering services. American Journal of Public Health 2013; 103(2):316-321.

[4] For more on the QUEST project see http://www.ucl.ac.uk/quest

[5] http://webarchive.nationalarchives.gov.uk/20080814090336/http://dhcarenetworks.org.uk/csed/Solutions/supportRelatedHousing/?parent=5322&child=5324

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				and suggest that there are substantial cost savings to be made through the provision of different types of housing services. One of the case studies compared annual care costs of a year in a hostel-based service "Next Steps" that included support from a key worker and coordination of support from other services, with care provided in the year before use of the hostel. The service run by a housing association in Manchester was estimated to have a reduction in annual care costs per tenant of between £11,000 and £20,000, with 17 of 19 former tenants having sustained independent living[7] . In another very small case study, savings of around £20,000 per person per annum were found when making use of purpose built flats provided by a housing association in London for people with severe mental health needs to help them move towards more independent living[8]. About 18% of these cost savings would be for social care services and 82% for health services. The problem with these case studies, welcome though they are, is that they have not been designed to determine whether the service is actually effective, which creates a large degree of uncertainty for service commissioners. On the positive side, however, they do indicate that relatively modest rates of success will generate an economic return. **Modelling studies for generic housing support and specialist accommodation (limited evidence, 2+, cost effective)**	

[6] Department of Health. No health without mental health: a cross-governmental mental health outcomes strategy for people of all ages. Supporting document – the economic case for improving efficiency and quality in mental health. London: Department of Health, 2010.

[7] See Support Related Housing Case studies. Next Step Project. Resettlement project for men aged 30+ with enduring mental illness. http://webarchive.nationalarchives.gov.uk/20080814090336/http://dhcarenetworks.org.uk/_library/Resources/CSED/CSEDProduct/nextstep01.pdf

[8] See Support Related Housing Case studies. Enabling People with Severe Mental Health Needs to make the Transition from Hospital/ Residential Care to Sustainable Community Based Living http://webarchive.nationalarchives.gov.uk/20080814090336/http://dhcarenetworks.org.uk/_library/Resources/CSED/CSEDProduct/pondersbridge01.pdf

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				There have been some very broad economic modelling studies of the impact of housing support and specialist housing initiatives. Several studies have looked at the economic impacts of the former Supporting People programme which has funded some housing support services in the UK since 2003. The studies suggest a small positive return to the economy as a whole for investing in these programmes of between £1.10 and £2.10 for every £1 invested, but they are not focused on impacts on the NHS. In the absence of robust data many assumptions have had to be made about their effectiveness[9], [10]. They cover a very broad range of client groups including ex-offenders, people with intellectual disabilities and homeless people. The Homes and Community Agency also commissioned economic analysis of capital investment in specialist housing for vulnerable people in England. This analysis reported a positive return on investment for most client groups, except teenage parents, young people at risk and young people leaving care. Costs avoided as a result of better health outcomes were estimated, drawing on effectiveness evidence sometimes from robust studies and sometimes from small scale evaluations in England. For older people annual financial benefits of almost £3,000 per annum were estimated; half of this would be benefits to the health system. The benefits to the health system of new specialist housing for people with mental health needs were more than £12,500 per annum, of which £11, 750 would accrue to the health system[11].	

[9] Tribal Consulting. Supporting People: Costs and Benefits. Edinburgh: Scottish Government Social Research, 2007

[10] Ashton T, Hempenstall C. Research into the financial benefits of the Supporting People programme 2009. London: Department for Communities and Local Government, 2009.

[11] Frontier Economics. Financial benefits of investment in specialist housing for vulnerable and older people. A report for the Homes and Communities Agency. London: Frontier Economics, 2011.

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				I would also recommend reading: Mental Health and Housing: Housing on the Pathway to Recovery written by the National Mental Health Development Unit	
National Housing Federation	Short version	14	5	This section is missing something that looks at whether the right housing options are available. It may be that someone would be better discharged into supported accommodation which may or may not be available. The guidance should provide a prompt here which would encourage commissioners to factor this into mental health provision.	Thank you for your comment. Please note that NICE social care guidelines do not make recommendations specifically directed at commissioners or about issues around shaping the local care and support market. However, 'Accommodation' now appears as a subsection of section 1.5 on 'Discharge'. There are 2 recommendations within this – one about ensuring that the accommodation someone is being discharged to is suitable for them (1.5.7), and another about giving people who are homeless, or at risk of homelessness, structured support to find and keep accommodation (1.5.8). Adhering to the principles of supporting people in transition in the least restrictive setting has also been added as an overarching principle of the guideline (1.1.3).
National Housing Federation	Short version	16	26	Similar point to above, this section is missing something that looks at whether the right housing options are available.	Thank you for your comment. 'Accommodation' now appears as a subsection of section 1.5 on 'Discharge'.
National Housing Federation	Short version	17	25	This list should include suitability of accommodation	Thank you for your comment. The Guideline Committee agreed with your comment and 'suitability of accommodation' is now included on the list of things which should be covered in the assessment (see 1.5.21).
National Housing Federation	Short version	19	7	Could this include housing and support providers	Thank you for your comment. The list has stemmed from evidence which was specific to these services. However, the list is not intended to be exhaustive. Housing is covered by this guideline so although it is not listed in this recommendation (1.6.4) housing and support providers would still be covered.
National Housing Federation	Short version	24	4	I'm surprised this section doesn't give some recommendations on which services to commission and the importance of looking at integrated delivery across housing, health and care (such as the Tile House project in King's Cross by One Housing and	Thank you for your comment and for highlighting examples of services that promote integrated delivery across housing, health and care. Many stakeholders and Guideline Committee members referenced publications from the Improving Recovery

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				CANDI)	through Organisational Change (ImROC) programme. The ImROC programme is now referenced under the implementation challenge 'Delivering services that are person-centred and focus on recovery'. If you feel that the services you have mentioned align well with this guideline and would help to support implementation please consider submitting a shared learning example on the NICE website.
National Housing Federation	Short version	7	4	This should include housing teams or local housing provider	Thank you for your comment. The guideline committee agreed with your suggestion that 'housing support teams' has been added to 1.2.8.
Otsuka Pharmaceuticals UK Ltd	Full	General	General	We welcome the overarching principles set out in the draft document and the aim to ensure patient centred recovery focussed transition between services. The explicit reference to the importance of a care plan and involvement of carers and families is timely and reinforces the broader agenda for carer support and involvement. However, the guideline as drafted is attempting to provide a 'one size fits all' approach to a very diverse patient population – of all ages and with a comprehensive range of mental health problems including dementia. We are concerned that this approach will do little to support commissioners and service providers to develop and implement transition arrangements that are sensitive to the particular needs of patients and aligned to the patient pathways. Ultimately this would lead to little if any improvements for patients and families as they navigate complex and potentially confusing mental health services at a stressful time. NICE has developed and published clinical guidelines that set out the arrangements and expectations of services for a range of mental health conditions and dementia, in addition to already recognising that transition from child and adolescent service to adult services. It is noteworthy that NICE in these guidelines has understood the specific requirements different patient populations and	Thank you for your supportive comments. NICE has, indeed, produced guidance that is pertinent to the variety populations described in this guideline. We anticipate that people will be able to find the most appropriate guidance for them by the links provided via NICE pathways. However, we do note your particular suggestion about the case for tailored guidance for people living with dementia. As the work on this guideline did not identify any studies about transition for people with dementia from or to inpatient mental health settings, the committee decided that they wished to make a research recommendation on this topic.

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				different mental health conditions need. We recommend strongly that NICE considers developing a range of transition guidelines that will work alongside its existing clinical guidelines. In particular, this is very relevant to separate dementia from all other mental health conditions. In doing so NICE will be better placed to provide specific, detailed support to service users, service providers and commissioners.	
Rethink Mental Illness	Short	11	18	It is important that the named practitioner does not just give information to families, parents and carers but is also a point of contact for carers to raise concerns and flag important information. Adding a line to that effect in this list of points under 1.4.1 would echo the intention of recommendation 1.2.4 about drawing on the expertise and knowledge held by carers and families.	Thank you for your comment. As you say, the recommendations highlight the importance of drawing on the expertise and knowledge of carers – one of the overarching principles of the guideline is to work with the person to explore ways in which their support network can be involved throughout their admission and discharge (1.1.5). While the guideline advocates a collaborative approach to working with carers and families elsewhere, 1.4.1 comes under the section on 'Support for families, parents and carers'; the focus of this particular recommendation is on informing and supporting them.
Rethink Mental Illness	Short	14	5	It would be helpful if the section on discharge could be framed in terms of the principle of supporting people in the least restrictive setting, as is set out in the Mental Health Act and its Code of Practice.	Thank you for your comment. The Guideline Committee felt the point about supporting people in transition in the least restrictive setting was extremely important and, as such, it was added as an overarching principle (see 1.1.3)
Rethink Mental Illness	Short	19	22	As above, the principle of supporting people in the least restrictive setting as set out in the Code of Practice could be highlighted here.	Thank you for your comment. In light of your and other stakeholder comments concerning the use of the least restrictive setting a new overarching principle has been added to the guideline. 1.1.3 states: "Support people in transition in the least restrictive setting available (in line with the MHA 2007 and its Code of Practice).
Rethink Mental Illness	Short	23	16	We welcome the focus on person-centred and recovery-focused care as a priority for implementation. This is something that relates to all the recommendations, not just those listed in line 19 on this page. There is also a significant overlap between this and the challenge outlined on page 25,	Thank you for your supportive comments. A number of guideline committee members have also highlighted the ImROC programme to us too. We have added reference to the resources you suggest in updating the section on 'implementation getting started'.

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				line 22 around co-producing care plans. If people are meaningfully involved in developing their care plans and defining their individual recovery journey, then a person-centred approach should follow. These could therefore be treated in a similar fashion. In terms of good practice in embedding these principles, the publications from the Improving Recovery through Organisational Change (ImROC) programme would be a useful reference point. Four in particular are potentially relevant here: Recovery: a carer's perspective, Making Recovery a Reality in Forensic Settings, Supporting recovery in mental health services: quality and outcomes and Peer support workers: a practical guide to implementation.	
Rethink Mental Illness	Short	23	16	Many people report remaining in a secure hospital after their clinical teams say they are ready to be discharged. One key reason for people remaining in secure care is the significant lack of appropriate community provision and support for people leaving secure mental health services. Secure mental health services are commissioned at a national level by NHS England (NHSE), whereas community-based placements are funded by local Clinical Commissioning Groups (CCGs) and/or local authorities. These local bodies are often not aware of the particular needs people may have after being in secure care. The fragmented commissioning and funding approach can therefore result in little join up between all the relevant agencies, delays and inadequate provision. In short, this poses challenges to a timely, clear and, crucially, person-centred 'secure care pathway'. This is likely to be one of the biggest implementation challenges for these guidelines and NICE addressing this in their guidance could be really helpful. Appropriate community support should be available to facilitate the timely discharge of people from secure mental health services to their choice of location. This should include suitable supported accommodation,	Thank you for highlighting these challenges. The evidence considered by the committee did not allow for them to make specific recommendations in this area, due to a lack of high quality and high relevance papers. The reviewer did not look at evidence on the range of community service provision or the funding of services at a local level.. Nor were they in a position to make recommendations about funding or market supply. However, we do expect that commissioners of mental health services – whether from a national level (NHSE) or by local CCGs will take account of the recommendations – including the overarching principles such as 1.1.7 that emphasises the need for people with mental health services in transition to have equal access to services, based on clinical need. 1.2.1 has been amended to state that assessments for people in crisis should be prioritised.

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				forensic outreach teams and employment opportunities, such as Individual Placement and Support (IPS). Better community provision and crisis care for people with severe mental illness could also prevent some admissions to secure services and reduce the risk of readmission for those discharged from those services.	
Rethink Mental Illness	Short	8	24	In addition to the existing recommendation, we would suggest that care coordinators from community settings managers should also be present at inpatient Care Programme Approach (CPA) reviews to facilitate a smooth discharge process, particularly from secure mental health services.	Thank you for your comment. The GC felt that adding 'care coordinators from community settings managers' was too prescriptive.
Rethink Mental Illness	Short	General	General	Rethink Mental Illness welcomes these draft guidelines, in particular their focus on person-centred care. We are pleased that secure settings also fall within the scope of this guidance as we know discharge can be particularly problematic from these settings due to complex funding and commissioning arrangements. This is particularly pertinent following the publication of the independent Mental Health Taskforce's report earlier this year. The Taskforce made recommendations relevant to secure mental health services, with a focus on commissioning arrangements for secure mental health services and ensuring appropriate services are available when people leave hospital. Rethink Mental Illness has particular expertise in this area as we deliver two programmes of work in secure mental health services that are contributing to the national policy agendaR 1. We manage a network of nine regional Recovery and Outcomes Groups (ROGs). These groups bring together people living and working in secure services with their commissioners to encourage services to share best practice, discuss difficulties and potential developments. These groups feed	Thank you for bringing this information to our attention. Since the key implementation challenges highlighted relate to delivering services that are person-centred and focused on recovery and to co-producing care plans, the work you are doing seems to be very much aligned with and can support implementation of the guideline. We would encourage you to consider submitting a shared learning example on the NICE website.. We would also draw your attention to the research recommendation on peer support on page 32.

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				directly into the commissioning processes of NHS England and help inform national pieces of work relating to secure services. These groups were first formed in 2012 and, since 2015, they have been organised and facilitated by Rethink Mental Illness with funding from NHS England. 2. We coordinate the Rethink Mental Illness Innovation Network, which runs two pilot projects in secure mental health services. The network brings together 11 NHS trusts, an independent provider and Rethink Mental Illness as a voluntary sector provider. We implement improvements in care and evaluate these to support the development of an evidence base around best practice. The two recovery-focused projects in secure mental health services are piloting approaches to collaborative care and risk planning, and peer support. We will be publishing an evaluation of these in summer 2016 and we are confident that this will demonstrate the importance of involving people in their care and the benefits of peer support. This is particularly important in the most restrictive parts of the mental health system and should serve as a model of good practice in other settings.	
Royal College of General Practitioners	Short	11	Section 4 - Triangulation Of Care	Families and carers commonly feel excluded by mental health services from their relative's care, and experience high levels of stress particularly as their children and young adults become 18 year old. The attitudes of adult mental services in sharing information is very different to those of paediatric and adolescent service. Whilst the staff have a duty of confidentiality to the young adults this is often appears to block carers and families enquiries. Reasonable adjustments are not explored as to how the needs of carers and family who will be providing 24 seven care after discharge, are not addressed.	Thank you for your comment and for bringing up the issue of carer inclusive practice. The case study which you have provided a link to would not meet our inclusion criteria for this review as it is a case study. However, the Guideline Committee discussed the importance of 'Triangulation of Care' and deemed it to be an important topic, especially in relation to children and young people, and young adults. The guideline covers carer inclusive practice in a

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				The RCGP has run a carers priority program and identified important case studies that seem to help in this situation. The Triangualation of Care patient care providing by a mental health trust in Somerset appears to address summary issues that families and carers experience and improve the transition. http://www.nhsiq.nhs.uk/media/2535977/carers_case_study_-_somerset_partnership.pdf (MH)	variety of ways. The whole of section 1.4 of the guideline is about supporting carers, parents and families, recognising that young people can be carers too; 1.5.7 is about discussing accommodation needs with carers; 1.5.21 is about sharing assessment (with person's consent). If you think that the lessons learned from the Triangulation of Care program aligns well with this guideline and would help to support implementation please consider submitting a shared learning example on the NICE website.
Royal College of General Practitioners	Short	General	General	A thoughtful and sensible document trying to improve care and support for a high risk and vulnerable group. It is based on expert opinion and practice rather than evidence based. Homelessness is a considerable problem, half way homes helpful. Returning a patient to a community where there have been disruptive episodes, bullying and abuse needs great sensitivity- neighbours can be fearful for themselves and their children and react angrily. The use of follow up and surveillance by telephone /skype can be helpful with the continued involvement of the Crisis Intervention Team. It can be a calculated risk, particularly where the patient may be a fire risk or where their behaviour is perceived as anti-social by neighbours. The Case Conference model helps with hard decisions. Day hospitals, attached to the in patient unit may enable a gentle and supervised transition to the community. Some patients will need long term care and support over months and years.	Thank you for your comment and for your positive response to the guideline. The Guideline Committee are very much involved in the development of the recommendations, however a systematic review of evidence is central to the process. Where there is a lack of evidence in a particular review area an expert witness is invited to speak to the Guideline Committee. Details of the review and of how the evidence links to the recommendations can all be found in the long guideline. The Guideline Committee likewise saw that homelessness is a serious issue for this population. 1.5.8 is about giving intensive, structured support to people who are homeless, or at risk of homelessness, while they are in hospital so that they can find and keep accommodation post-discharge. 1.5.7 is about ensuring the suitability of the accommodation to which the person is being discharged. No evidence was found on the effectiveness of rehabilitation or step-down facilities or day hospitals attached to the in-patient unit, in relation to hospital discharge or reducing readmissions so the Guideline Committee were unable to make recommendations in this area. The second research recommendation on

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				(PS)	'People with complex needs other than dementia' covers rehabilitation as an intervention to support people with complex needs during transition.
Royal College of General Practitioners	Short	General	General	The RCGP notes that there was no GP in the development group and the consultant psychiatrist Shawn Mitchell is associated with a private psychiatric hospital. Nevertheless the RCGP welcomes the involvement of service users, their representatives and carers and the study team. Overall this document is excellent because it is so much common sense and what should be normal compassionate working. What actually happens and the conditions in most psychiatric hospitals fall far short of these standards. I would hope that individuals, Trusts and the CQC can bring about change despite these times of austerity otherwise this hope will be lost. (JA)	Thank you so much for your positive response. Guideline committee members were selected through a transparent recruitment process on the basis of their knowledge and expertise in the topic area. As the published constituency states, for this GC we looked for a range of members (up to 12 or 15) with a particular or specialist interest in co-ordinated transition for people moving between inpatient mental health settings and community or care home settings. We also encouraged a range of applications to reflect experience from rural and urban communities and different localities, GPs were specifically identified as potential members, along with other health practitioners. . On this occasion we did not receive a suitable application from a GP. However, we were very satisfied that the composition of the committee ensured a wide range of perspectives. All members were required to make declarations of interest and of any potential conflicts of interest throughout the process. Details of the recruitment and role of Guideline Committees can be found on the NICE website We are aware of the multitude of issues that austerity measures have brought. We also hope that this guideline will help to instil a compassionate approach and best practice into everyday practice.
Royal College of Nursing	General	General	general	The Royal College of Nursing welcomes proposals to develop these draft guidelines.	Thank you for your interest.
Royal	short	10	14	The responsibility for ensuring that the ward to which	Thank you for your comment.

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College of Nursing				the person is admitted is safe and therapeutic has not been specified. There is a risk that it will be presumed that the responsibility is "someone else's" if not specified.	Recommendation 1.3.1. and 1.3.5 are both aimed at supporting inpatients to feel in control and that they ae in therapeutic environment. Although evidence in this area was of good quality, it was not strong enough around the roles of specific practitioners for the GC to assign responsibility to a specific professional. The recommendation which was originally 1.3.16 has been amended to make sure that it is an action-based recommendation. The first part of the recommendation overlapped with 1.3.1 so the first sentence was removed. It now focuses on making sure that people, particularly children and young people, know who they can talk to (now 1.3.20).
Royal College of Nursing	short	10	20 - 21	These lines should include a reference ensuring that information in communicated in a suitable format for those with communication and/or cognitive impairments.	Thank you for your comment. Providing accessible information which is in a suitable format for the person is an overarching principle of the guideline (see rec 1.1.8).
Royal College of Nursing	short	10	3-4	These lines do not provide for the admitting nurse or responsible person taking relevant actions to address concerns. In these circumstances it is vital that there are support mechanisms in place or which can be accessed by the admitting nurse or responsible person to provide the necessary support.	Thank you for your comment. The Guideline Committee's views were in line with yours and the phrase 'and liaise with the appropriate agencies' has been added to this recommendation (now 1.3.20) to make it more action-focussed.
Royal College of Nursing	short	12	24	There is a belief within the workforce that carers' assessments are nugatory as there is little support to be offered to carers if needs are identified. This must be considered and it is vital that there are support mechanisms which can be accessed to provide the necessary support.	Thank you for your comment. The section before the 'Carer's assessments' section contains many recommendations about how carers and families can be supported in transition beyond the carer's assessment: 1.4.2 is about building relationships with the person's family and carers during admission; 1.4.4 is about accommodating parents' or carers working patterns or other responsibilities so they can attend meetings; 1.4.6 is about giving carers and families clear information about the unit; 1.4.7 is about giving carers information about carers information about carer's support services.
Royal College of Nursing	short	17	12-14	Will the required "the named person from education setting" be available in all circumstances? Will education authorities be aware of their role within this section of the NICE guidance? This must be	Thank you for highlighting this point. As this guideline covers both adults and children, we will be ensuring that this guideline is disseminated to local authorities in their capacity as education authorities. The GC agreed

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				considered.	that sudden and poorly planned discharge was undesirable and so communication with education in the case of children and young people would be beneficial. This recommendation fits with 1.5.5 and 1.5.6 which specifically address the role of education settings.
Royal College of Nursing	Full	General	General	The guidance is good relating to the mental health needs of individuals but not strong enough on the maintenance and management of concurrent physical health issue. This is particularly important if the person is to be placed out of area it is vital that where they are placed have sufficiently trained staff to be able to care for people who have other complex physical health needs. I would also like to see not just family and carers mentioned but for some individuals it will be other people who are most important to them who may need to be involved in the decisions and conversations	Thank you for your comment. The Guideline Committee were aware of the importance of addressing co-morbid physical health needs for this population. A research recommendation has been made for the population of 'people with complex needs' undergoing transition and this covers people with significant or complex mental health needs and concurrent physical health care needs. The guideline references physical health care needs in the following recommendations: 1.2.7, 1.3.19, 1.3.22, 1.5.20 and 1.6.1 The guideline committee felt that 'people who are most important' to the person undergoing transition (as opposed to families or carers) was covered in the overarching principles; 1.1.5 is about identifying a person's support networks and working with the person to explore ways in which the people who support them can be involved during transitions.
Royal College of Nursing	Full		1.6.20	The discharge summary should also be emailed to the services who were previously involved in the persona carte if they are going back home having been out of area and in some cases to family to ensure that everyone relevant is familiar with the progress and the proposed plan of support in case the GP or the individual delay sharing the information	Thank you for your comment. This recommendation received a lot of comments from stakeholders, and in light of your and other comments it has been amended considerably. The Guideline Committee agreed that the discharge summary (a longer document outlining details of why the person was admitted and what happened during someone's stay) should be sent to people who are on the person's care plan (subject to the person's agreement) as well as the person's GP.
Royal College of Paediatrics and Child Health	NICE version	general	general	Although parents and carers are mentioned, the implication is that the young person, who may be a child, has autonomy and is capable of informed decision making. This assumption is a concern to many parents	Thank you for your comment. The population for this guideline is very broad. In the light of your comment and concerns raised by other stakeholders that some of the recommendations were not appropriate for the children and young people population, the Committee considered this very

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				especially those with learning difficulties.	carefully. Members identified a number of areas where they amended wording to clarify whether or not they apply to children and young people or just adults. For example, 'people' was replaced with 'adults' in 1.5.12 on group-based psychological interventions for people with bipolar disorder to show that condition-specific psychoeducation interventions are unfeasible for a children and young people population. Section 1.4 specifically addresses the need to build relationships with family members, parents and carers from the outset, achieving the delicate balance between ensuring children and young people have a voice as well as supporting those who care for and about them.
Royal College of Paediatrics and Child Health	NICE version	general	general	The importance of learning difficulties (intellectual disability) and other neurodevelopmental disorders such as autism in both while inpatients and with regard to discharge planning needs to be highlighted—it is acknowledged in the 'challenges to implementation'	Thank you for your comment. 1.6.4 recommends that if a person has a learning disability or is on the autistic spectrum the hospital team should lead the communication about discharge planning with the various services that support the person in the community, such as learning disability services.
Royal College of Paediatrics and Child Health	NICE version	general	general	'Who' is the person taking responsibility for all the coordination? We realise that NICE does not comment on this but this will be another challenge to effective implementation.	Thank you for your comment. Given the diversity of people and populations covered by this guideline, we know that local practice may differ in defining who is responsible in all circumstances. The guideline committee have offered a steer in some of the recommendations where they can be a bit more specific. For example, in 1.3.11, for those people placed out of area, the recommendation now says 'The named practitioners from the person's home and the ward should work together to ensure that the person's current placement lasts for no longer than required.' Other recommendations such as 1.3.17 and 1.3.18 refer to 'the admitting nurse or person responsible'. But, overall, the committee recognise that it will be for local organisations to decide within the context of overarching principles set out in 1.1.
Royal College Psychiatrists				The Rehabilitation and Social Faculty thanks NICE for its helpful guidance. This guidance considers and issue which members of the Rehab and Social Faculty are challenged with when managing service	Thank you for your comments and support for this guideline. Expert witnesses for both the dementia and children

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				users in Liverpool. The guidance notes visiting an inpatient unit in advance. This should be offered but in some cases this may need to occur more than once. There should be an appointed co-ordinator/ case manager for transition to enhance the process. There needs to be a consideration of their functional abilities in the new settings and this may need to be assessed as appropriate Often following transfer it is helpful for the previous service to still be available to provide telephone support if required around any care issues. The rehab and social faculty would also like to draw NICE's attention to the evidence for locally commissioned mental health rehabilitation services and supported accommodation services in ensuring successful community discharge for people with complex psychosis. A recently published national cohort study has shown that 56% of this group are successfully discharged to the community when local inpatient mental health rehabilitation services and appropriately supported accommodation services are available. The cost analysis showed that there was an associated decrease in costs of care over the 12 months of the cohort study. A further 14% of patients could have been discharged but were awaiting a vacancy in appropriately supported accommodation (suggesting under resourcing of these services). Please see the attached paper for further details: Killaspy et al. Clinical outcomes and costs for people with complex psychosis; a naturalistic prospective cohort study of mental health rehabilitation service users in England, BMC Psychiatry, 2016, 16:95. DOI: 10.1186/s12888-016-0797-6). In addition, this study has shown that the degree to which the inpatient mental health rehabilitation service adopts a Recovery Orientation is positively associated with	and young people review areas informed the GC about the importance of facilitating a visit to the inpatient unit in advance of admission, or at the very least, showing them some videos or pictures of the ward they are going to be admitted to. The GC agreed that this would constitute good practice and made recommendations 1.2.5 and 1.2.6 as a result. The GC did not specifically consider evidence about whether visits might need to happen more than once nor whether a dedicated role might be required to facilitate this. Being focused on the overarching principle that the aim of care and support for people in transition is person-centred and focussed on recovery, some practice variation may well be acceptable as long as it addresses the needs and requirements of the person and their circumstances. However, the Committee did agree that it is important for a person who is admitted outside the area they live to identify a named practitioner for the person's home area and for the ward they are being admitted to. (See 1.3.11) As you say, it is helpful for inpatient services to have contact with previous services following discharge so that they can exchange information about the person and their care needs. 1.2.8 emphasises the importance of ensuring ongoing communication between the inpatient team and any other services that have been previously involved in the person's care. Thank you for the helpful additional information supplied and offer of additional help with queries. The points you highlight about the importance of ensuring a local mental health rehabilitation care pathway for people with complex mental health needs are well made. The 'In sight and in mind' toolkit, though it provides some very valuable material, did not meet our inclusion criteria The Killaspy paper was published in April 2016, so it was not picked up in our update search. Rehabilitation is not explicitly referred to in the scope but neither is it listed as an excluded setting or

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				successful discharge. This reinforces many of the important points in your guidance, but we believe this is the first empirical evidence of a clear association between recovery based practice on 'hard' clinical outcomes and it is of particular interest that this has been shown now for those with the most complex needs (mental health rehabilitation service users). The Rehabilitation Faculty of the Royal College of Psychiatrists have also published and contributed to others' publications on the subject of "out of area treatments". It is clear that without adequate investment in a local mental health rehabilitation care pathway, people with complex mental health needs are at great risk of exportation to socially dislocating placements many miles from home in a range of facilities (e.g. so called 'locked' rehabilitation units, usually provided by the private sector, as well as nursing and residential care homes). We have attached relevant documents that you may also find useful. The DH also previously commissioned the following guidance for mental health commissioners on this topic which also contains many useful references: http://www.rcpsych.ac.uk/pdf/insightandinmind.pdf Please see the relevant documents attached to the email this comments form was sent with. The Rehab and Social Faculty are of course happy to answer any queries on the above.	activity. By nature of the guideline rehabilitation would only be considered as an intervention or approach designed to improve transitions or reduce readmissions. By virtue of having successful community discharge as a main outcome measure the review team looked at the paper and concluded that as the study was exploratory, and the findings of the study do not definitely demonstrate effectiveness, it was not possible to write an evidence statement based on this study alone. The Killsapy paper was discussed with the GC at the last meeting (GC12) and while they saw that this was a promising, emerging area of research on a high cost complex group it was not possible to write any new recommendations on inpatient rehabilitation services for people with complex psychosis at this stage. However, the discussion led to 'people with complex psychosis' being added as a specific group of people who are covered in the research recommendation for 'People with complex needs other than dementia'.
Royal College Psychiatrists	long	314	20-26	Include 'general hospital staff, especially those working in the Emergency department and on acute admission, trauma and elderly care wards.'	Thank you for your comment on our implementation challenges. 'General hospital staff and psychiatric liaison staff' has been added to the list of professionals involved in assessments for admission under the MHA who should have opportunities for training.
Royal College	long	33	3-6	Include 'significant physical and mental health needs' in the section about people with complex needs other	Thank you for your comment. The Guideline Committee agreed to amend the

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Psychiatrists				than dementia	wording within the research recommendation for people with complex needs other than dementia to "interventions to support people with complex needs because of multiple diagnoses and resistance to treatment"; people with physical disabilities are also listed in the examples of groups this might cover.
Royal College Psychiatrists	long	5	4-5	Add 'including general hospitals' after 'community'	Thank you for your comment. This request does not align with the scope for this guideline. This guideline did not look at a transitions between general hospitals and inpatient mental health hospitals, but only transition from inpatient mental health settings to community and care home settings. The sister guideline [NG27] Transition between inpatient hospital settings and community or care home settings covers transitions from general hospitals.
Royal College Psychiatrists	long	6	3	Add 'including general hospitals' after 'community'	Thank you for your comment. This request does not align with the scope for this guideline. This guideline does not look at a transitions between general hospitals and inpatient mental health hospitals, but only transition from inpatient mental health settings to community and care home settings. The sister guideline [NG27] Transition between inpatient hospital settings and community or care home settings covers transitions from general hospitals.
Royal College Psychiatrists	long	7	30	Add 'people with significant physical and mental health needs	Thank you for your comment. The guideline implicitly covers people with significant mental health needs as its whole population because it is about transitions to and from mental health inpatient settings. The groups highlighted here are particular sub-groups of this population who have been known to experience difficult transitions. People with physical disabilities are highlighted as a high risk sub-group.
Royal College Psychiatrists	short	1		Who is it for: add providers and front line staff in general hospitals, including Emergency Departments	Thank you for your comment. This guideline does not cover general hospitals, it only focusses on transitions from inpatient mental health settings. Transitions from general hospital are covered in the sister guideline: Transitions between inpatient hospital settings and community or care home.
Royal	short	1	16	For child and adolescents (C&A), integrated working	Thank you for your comment.

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College Psychiatrists				with education is essential, as well as social care	There is a section of the guideline 'Education – for people under 18' which emphasizes the importance of integrated working between mental health and education for children and young people.
Royal College Psychiatrists	short	15	16 (1.6.6)	The child and adolescent faculty would agree that carers groups in C&A units are an essential part of discharge planning, however, in generic units it is not possible to necessarily tailor these groups for individual conditions, as, by definition, generic units admit C&A with a wide variety of disorders, and it would not be feasible to tailor run these groups in a disorder specific way. For more common disorders, eg eating disorders, specific groups could be feasible in community settings	Thank you for your comment. The Guideline Committee discussed your point and agreed that it would not always be possible to tailor carers' psychoeducation groups to individual conditions. Nevertheless, the committee felt that the groups should still signpost to where carers could access information on specific conditions. 1.5.11 has now been reworded in light of this.
Royal College Psychiatrists	short	15	3 (1.6.4)	Group sessions are not feasible for C&A where bipolar disorder (BP) is a relatively rare disorder; also groups may not be acceptable for some individuals; the recent BAP guidelines for BP (Goodwin et al 2016) also recommend consideration of family and individual approaches for psychoeducation.	Thank you for your comment. The Guideline Committee agreed with your point about the questionable feasibility of a bipolar disorder-specific group-based psychological intervention for children and adolescents. The word 'person' in 1.5.12 has been amended to 'adult' in order to clarify this.
Royal College Psychiatrists	short	19	17 (1.6.24)	The child and adolescent faculty are very concerned about the implication that young people who have been admitted for self-harm are not receiving treatment in the community. We would strongly endorse the need for these YP to be given adequate community treatment on discharge from hospital as they are a high risk group of YP, with a high risk of further self-harm, re-admission, and completed suicide. The implication that they should be left without community mental health resources and left to find support for themselves is extremely concerning for this highly vulnerable group of young people. All YP who are being discharged from an inpatient unit should be given adequate follow up and support from mental health services in the immediate period after discharge in order to reduce risks and ensure a safe transition. In the case of YP who have had repeat admissions for self-harm, they should be discharged with a robust community mental health package which	Thank you for your comment. The Guideline Committee acknowledged that this recommendation was a just cause for concern and agreed to amend the wording of 1.6.9 to say 'For adults admitted for self-harm' in order to avoid any possible confusion. The wording and order of recommendations 1.6.6.and 1,6.7 have also been specifically amended to conflate discharge planning and suicide risk,

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				is likely to involve other services with a crisis plan and management plan which aims to reduce the need for further admissions which may be detrimental.	
Royal College Psychiatrists	short	27	1-5	Include general hospital so it reads 'Key issues in....and different pressures and knowledge between general and mental health staff. All can result....'	Thank you for your comment. This guideline does not cover general hospital settings, it only focusses on transitions from inpatient mental health settings. Transitions from general hospital are covered in the sister guideline: Transitions between inpatient hospital settings and community or care home.
Royal College Psychiatrists	short	6	3	Add 'general hospital workers' to the line 'staff such as.....'	Thank you for your comment. However, this guideline does not cover general hospital settings, it only focusses on transitions from inpatient mental health settings. Transitions from general hospital are covered in the sister guideline: Transitions between inpatient hospital settings and community or care home.
Royal College Psychiatrists	short	7	8	Add a line 9 'general hospital and liaison psychiatry teams'	Thank you for your comment. The guideline committee agreed that communication for this pathway was important and agreed to add the bullet point 'general hospital or liaison psychiatry teams' to 1.2.8.
Royal College Psychiatrists	Short and long	general		The child and adolescent faculty broadly welcomes this thorough document which sets appropriate standards for transition. However we would like to draw particular attention to our concerns regarding the points made above and very much hope that the needs of this high risk group of YP will not be neglected in this guidance.	Thank you for your comment. The Guideline Committee discussed a number of points relating to the suitability of recommendations for the children and young people population. The committee decided that 1.6.9 should specify 'adults admitted for self-harm' in light of your comment that children and young people who self-harm should never be discharged without robust support from community mental health services. Changes were also made to the psychoeducation recommendations to reflect the fact that it may not always be possible to have condition-specific support groups for carers of children and young people.
Royal College Psychiatrists	Short and long	general		The liaison faculty says that admission from a general hospital is a significant pathway for mental health in-patient facilities. Such transitions are complicated not	Thank you for your comment and for highlighting this particular pathway into mental health in-patient facilities.

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				only by common factors in all admissions which are clearly addressed, but also by the different pressures and expertise across mental and physical healthcare in different organisations as well as, often, by complex physical and mental health co-morbidities. Therefore this source of admission, and the challenges to overcome, should be specifically included in the guideline.	This guideline was commissioned as a result of its sister guideline on transitions from inpatient hospital settings to community or care home settings as it was deemed too broad a remit to cover transitions from both general hospital and psychiatric hospitals within one guideline. Unfortunately, neither of these guidelines looked at transitions between inpatient settings, focussing instead on the inpatient to community transitions. However, the Guideline Committee acknowledged the significance of the general hospital to mental health in-patient settings pathway. In order to acknowledge the importance of communication at the interface between these two settings 'General hospital or psychiatric liaison teams' has been added to the list of services with which the inpatient team should ensure ongoing communication.
Shared Lives Plus	Short	14	7	Discussing housing need will significantly inform discharge planning but may present resourcing issues.	Thank you for this point. The Guideline Committee felt that discussing and planning for their housing needs with the person and their family or carers was an integral part of a person-centred approach to helping them get ready for discharge (see 1.5.7). They also thought that suitability of accommodation should be considered as part of the thorough assessment of the person's personal, social, safety and practical needs to support discharge (see 1.5.21). The committee did not identify additional resourcing issues for this.
Shared Lives Plus	Short	15	19	Good to have one person responsible for writing the recovery plan.	Thank you for your support of this recommendation.
Shared Lives Plus	Short	17	15	Involving the receiving organisation in discharge planning will be essential and require good communication and clear referral information.	Thank you for your support for this recommendation. Other recommendations in the guideline focus on the need for good communication and information sharing between inpatient staff and receiving services. 1.6.3 is about ensuring that a (recovery-oriented) care plan is sent to everybody involved in the person's care within 24 hours, and that a discharge summary is sent to the person's GP and others agreed on the person's

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					care plan (subject to the person's agreement) within a week of discharge and 1.6.4 deals with individuals who have austim, dementia and/or a learning difficulty and the necessary communication between hospital staff and community services.
Shared Lives Plus	Short	17	20	Sharing the discharge summary and recovery plan with all involved in discharge will be important to its success.	Thank you for your comment and support for our guideline. 1.6.3 is about ensuring that a (recovery-oriented) care plan is sent to everybody involved in the person's care within 24 hours, and that a discharge summary is sent to the person's GP and others agreed on the person's care plan (subject to the person's agreement) within a week of discharge.
Shared Lives Plus	Short	17	5	Phased leave is important and a range should be on offer, including for example lesser known options such as Shared Lives short breaks.	Thank you for your comment. The recommendation about phased leave and return to work have been left intentionally broad to allow for a person-centred and flexible approach.
Shared Lives Plus	Short	29	12	Where appropriate, developing ways of working creatively with little known or underused services in the home or community such as that provided by Shared Lives could improve choice and range of options for people with complex needs.	Thank you for your comment. The Guideline Committee identified interventions to support people with complex needs during transitions as an important area for research. The proposed research would evaluate rehabilitation and other mental health services - including residential placements - which allow the person to live in the community after discharge from inpatient mental health settings.
Shared Lives Plus	Short	5	14	It may be challenging for professionals to have a comprehensive and up to date knowledge of all available local services for people to choose to access.	Thank you for highlighting this challenge. The committee agreed that effective communication between teams and with people using services and carers is important to ensure person-centred care and support. We expect that different localities and systems will have different approaches to ensuring that practitioners are aware of services available locally and, where we identify good examples through implementation support, we will encourage localities to submit for shared learning.
Shared Lives Plus	Short	6	26	Good to see it is recommended that full records be kept.	Thank you for your support for this recommendation.
Shared Lives	Short	7	1 and 10	It will be essential to ensure good communication	Thank you for your comment. The recommendations

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Plus				between all parties involved in discharge, crisis planning and transitional care and support.	encourage collaborative working and good communication between teams involved in transitions. 'Ensuring effective communication between teams, and with people using services and their families and carers' is also an implementation challenge which is addressed in the guideline.
Shared Lives Plus	Short	general	general	Communication and coordination of discharge and other plans is a key thread throughout the guidance. This may have resource implications and be challenging to implement effectively.	Thank you for your comment. We agree that communication and coordination are both critical to smooth transitions and this is highlighted as a key implementation challenge. The committee agreed that communication between practitioners and teams and with the person and their family or carers is fundamental to ensuring the best possible experience and outcomes for people in transition between services and already reflects practice in some areas. The implementation section on page 26 suggests things that commissioners, managers and health and social care practitioners can do to improve communication.
Tees Esk and Wear Valleys NHS Foundation Trust		304	1.6.20	'Consider booking a follow up appointment with GP within 2 weeks of discharge'. This may be impractical as different surgeries operate different booking systems and it may not be possible to achieve. Responsibility for this should not lie with the inpatient team. Follow up during this time will be provided by community LD teams and if there were any specific health issues then an appointment could be booked.	Thank you for your comment. This recommendation (1.6.3) was based on evidence that an intervention encouraging communication between the psychiatrist and the GP of a person approaching discharge significantly reduced readmissions. This included the psychiatrist making the first follow-up appointment in the immediate post-discharge period and giving a discharge summary to the GP. The GC felt that it was important to involve a GP at an early stage after discharge because the person might only have a limited amount of medication to take home with them. As the GC also acknowledged that it may not always be practical for hospital practitioners to make this appointment the wording of the recommendation is 'weak' i.e uses the word 'consider'.
Tees Esk and Wear Valleys NHS Foundation	Full	264	HA11	We agree that people with LD may feel disempowered on non- LD mental health wards	Thank you for your comment and support for this particular evidence statement.

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Trust					
Tees Esk and Wear Valleys NHS Foundation Trust	Full	269	Economic considerations	Agree that people with LD should not be placed in expensive out of area units. Cost to individual and family and local services find it harder to maintain contact.	Thank you for your comment and support for this economic consideration.
Tees Esk and Wear Valleys NHS Foundation Trust	Full	274	HA12	Carers of people with LD need to have good access if people with LD are admitted to mainstream mental health services. Staff should have training on Diagnostic Overshadowing to allow them to discriminate between LD and mental health problems	Thank you for your comment. Carer involvement and relationship building with carers are themes throughout the guideline. In relation to carers of people with LD, 1.3.22 highlights the importance of working with carers and specialist services to provide support and continuity of care for someone with additional need for support, which would cover people with LD admitted to a mainstream service. We acknowledge that diagnostic overshadowing presents a large problem in this particular area, however no evidence on this topic was found in the review.
Tees Esk and Wear Valleys NHS Foundation Trust	Full	287	1.53	There is a need to support people with LD and mental Health or Complex behaviours in LD assessment and treatment services that are close to home to allow community and family links to be maintained.	Thank you for your comment. The Guideline Committee were mindful of the importance of avoiding out-of-area admissions wherever possible (for all populations, including people with LD). However, since, in practice, people with LD are placed out-of-area, recommendations 1.3.10 and 1.3.11 emphasise ways in which the risks of adverse effects of these placements can be mitigated.
Tees Esk and Wear Valleys NHS Foundation Trust	Full	294	1.6.8	Different terminology is used in different organisations e.g. the 'recovery plans' appear to have the same content as CPA documentation used in our Trust	Thank you for your comment. In light of your and other stakeholder comments, the Guideline Committee considered ways in which the guideline could be clearer around its use of terminology relating to care and recovery planning. It was decided that the term 'recovery plan' was not widely-used or understood and that it would be preferable to refer to a recovery-focused care plan. Details of care planning and the care plan are laid down in detail throughout recommendations 1.5.15 -

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					1.5.20, and 1.5.17 highlights that the care plan should be based on the principles of recovery. The committee also felt that it was better to use 'care planning' more generally as opposed to referencing the 'care programme approach' in order to make sure the recommendations applied to as wide a remit as possible.
Tees Esk and Wear Valleys NHS Foundation Trust	Full	296	1.6.10	Peer support groups – this is unlikely to be possible in LD due to the ability of most and the low number of admissions/discharges (as groups of 12 are recommended).	Thank you for your comment. The recommendation wording is 'consider' and, moreover, it is intended to be aspirational (the guidance is not statutory). If there are obstacles within LD environments to deliver group-based, peer delivered self-management training, practitioners may consider adapting this recommendation accordingly.
Tees Esk and Wear Valleys NHS Foundation Trust	Full	299	1.6.13	Phased leave is recommended but this does not suit all e.g. patients with ASD	Thank you for your comment. The GC discussed your comment and amended the wording of the recommendation from 'arrange' to 'offer' to allow for eventualities in which phased leave may not be appropriate.
The National Autistic Society	Full	16	17-22	The offer of a visit to an inpatient unit would be an important part of a smooth admission for an autistic person, who may struggle to process verbal or written information provided in advance. We note that this has been recommended for "people with learning disabilities and other additional needs". We do not feel that this accurately or appropriately captures the needs of autistic people (many of whom will not have a learning disability), who would also benefit from a visit prior to admission. We recommend that a new bullet point be added: "people on the autism spectrum".	Thank you for your comment. The Guideline Committee agreed that people on the autistic spectrum should be highlighted and this population has been added as a bullet point to 1.2.5.
The National Autistic Society	Full	16	3-8	We welcome the recommendation of more time and expertise to support people with more complex needs, including "people with dementia, or cognitive and sensory impairment." However, we believe that this should more explicitly refer to autism. Research suggests that one in 10 children in CAMHS, and 39% of the people in Assessment & Treatment Units (Learning Disability Census 2015) are autistic – 15%	Thank you for your comment. The Guideline Committee agreed that people on the autistic spectrum should be added to this recommendation

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				have autism and no learning disability. It is therefore a substantial number of people to whom this draft guideline applies. It is important that the draft guideline clearly applies these recommendations to autistic people. This could link with NICE Guidelines 142 and 170 on autism.	
The National Autistic Society	Full	17	23	We are concerned that "language needs" could be too narrowly interpreted to mean spoken language translation. Autistic people may find it difficult to communicate verbally and require advocacy. An advocate should be able to meet their communication needs and have received appropriate autism awareness training. We recommend the inclusion of "communication needs".	Thank you for your comment. The guideline committee agreed with your suggestion and 'communication needs' has been added to 1.3.4.
The National Autistic Society	Full	18	23 onwards	We believe that having a named practitioners if a person is being admitted out-of-area should indeed be included. However, we hear from parents and carers that where named practitioners are currently used, there is often a problem with consistency and attendance at meetings. We therefore recommend that a clause be added to ensure that, as far as possible the same practitioner stays with the individual. We also recommend that this clause stipulate that the named practitioner attend all relevant (e.g. Care Programme Approach) meetings.	Thank you for your comment. Within the GC there was a lot of discussion about how to ensure the maximum involvement of named practitioners. It was decided that it was logistically impossible to always have the same person at all meetings, as no professional is on call '24/7'. Rather, the emphasis of the guideline is on ensuring effective communication to ensure that the named practitioner, if unable to make every meeting or appointment, is at least kept as informed as possible.
The National Autistic Society	Full	29	26	We are concerned that the lead role for a hospital in communicating with agencies in the community only applies to people with a learning disability or dementia. As with the above points, we believe that autistic people would also benefit from this co-ordination role. We further note that the NHS in England has been tasked with reducing health inequality for autistic people, alongside those with a learning disability or dementia. We believe it is important that guidance at all levels promotes this, and recommend that autism be included here.	Thank you for your comment. The Guideline Committee agreed with your suggestion that people on the autistic spectrum should be added to this recommendation (see 1.6.4).
The National Autistic Society	Full	General	General	We welcome the development of this draft guideline. We acknowledge that it is looking across a wide variety of transitions from inpatient units. However, we believe that there are some instances where specific	Thank you for your comment and for your support for the research recommendation 'People with complex needs other than dementia'.

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				information relating to autism would be advisable. We further note the potential for this guideline to support NHS England's Transforming Care agenda, and highlight that this applies to autistic people in inpatient mental health units. We also welcome the research recommendation on autism.	In light of your comments, and their own experience of this group, the Guideline Committee added 'people on the autistic spectrum' to 1.2.4, 1.2.5 and 1.6.4. These recommendations are about allowing more time and expertise to support people with complex needs to make transitions to and from services; offering people the opportunity to visit the inpatient unity before they are admitted; and ensuring communication between the hospital team and services that support the person in the community.

Registered stakeholders: https://www.nice.org.uk/guidance/GID-SCWAVE0711/documents/stakeholder-list-2