NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Guideline scope

1 Guideline title

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

2 Remit and background

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

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

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

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

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

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

3 Need for the guideline

3.1 Key facts and figures

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

3.1.2 Delays in transferring people from an inpatient mental health setting may mean that they remain in hospital unnecessarily after they have been assessed as ready to go home (or to another setting). In a postal survey of mental health trusts, a wide range of interrelating factors were identified as contributing to delayed discharges (Lewis and Glasby 2006). This included a lack of funding for ongoing support and awaiting assessment for support, care home placement and further NHS funding. A more recent study of 1 inpatient mental health service in England provides similar findings. The reasons identified for delayed discharges included a lack of available beds, failure to find a suitable facility, awaiting a funding decision and delays in implementing a care package for support at home.

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

3.1.4 The University of Manchester's 2014 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness found that, between 2002 and 2012, 3225 mental health patients died by suicide within the first 3 months of their discharge from hospital. The peak time for risk of suicide is 1 week after leaving hospital. The report underlines the need for careful and effective care planning before discharge and for more support, including early follow-up appointments, after discharge. In recognition of the consequences of poor aftercare, figures published from 2014/15 in the clinical commissioning group (CCG) outcomes data set will include readmission to mental health settings within 30 days. Emergency readmissions are used in the CCG figures as a proxy for outcomes of aftercare.

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

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

3.2 Current practice

3.2.1 Transition can be particularly difficult for certain groups including: people with communication difficulties or sensory impairment; people who live alone; and people from minority ethnic groups. People placed out of area experience particular difficulties, including less contact with family and friends, increased risk of social exclusion, and reduced opportunities for employment and education (Rethink & Care Services Improvement Partnership). Case management and identifying when a patient is ready for discharge is also particularly challenging when placed out of area. This can result in longer stays in hospital and delayed discharges.

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

3.2.3 As well as consequences for the person using services, poor transitions can also have system level consequences. When transfers are delayed, hospital wards can become overcrowded, leading to insufficient staff being available and staff being overstretched. This can result in an increase in serious incidents, delays in admitting 'at risk' patients or the premature discharge of others, and negative effects on staff morale, retention and recruitment (A positive outlook: a good practice toolkit to improve discharge from inpatient mental health care National Institute for Mental Health in England). A lack of integration is a key cause of delayed discharges, both when inpatient and community mental health services do not work together effectively and when health, social care and housing agencies do not work together.

3.2.4 Guidelines on transitions generally focus on admission into or discharge from inpatient mental health settings. They fall into 2 categories: guidelines describing what people should expect (and are entitled to) in relation to their transition; and guidelines to raise awareness and improve practice among professionals involved in transition processes and cross-sector working.

3.3 Policy, legislation, regulation and guidance

3.3.1 Policy

- A key part of the UK mental health system, the Care Programme Approach was introduced in 1990 as the UK model for assessing, planning and reviewing care for people with mental health needs. The most recent update placed emphasis on supporting only people at higher risk or with more complex needs through the new Care Programme Approach (Refocusing the Care Programme Approach Department of Health).
- Children and young people can also receive treatment and support through this approach. It can be especially helpful if they are supported by specialist child and adolescent mental health services (CAMHS). Local protocols are needed to agree which system has the lead responsibility for child protection or mental health. Other considerations are also important in this context, such as taking a family-centred (rather than person-centred) approach to care planning ('Refocusing the Care Programme Approach').
- The Department of Health's National Service Framework for Mental Health, published in 1999, had a significant effect on service provision, including the establishment of 3 functional teams; assertive outreach, early intervention in psychosis, and crisis resolution and home treatment teams. These teams have particular significance for this guideline because they play a key role in preventing unnecessary admissions and supporting people on discharge from hospital.
- The national mental health strategy No health without mental health was published by the Department of Health in 2011 and sets out the government's long-term objectives for the transformation of mental health

care. This includes improving the health and wellbeing of the population and providing high quality services that are accessible to all.

- The national dementia strategy Living well with dementia was published by the Department of Health in 2011 and aims to ensure that major improvements are made to dementia services. The strategy makes 17 recommendations focussed on 3 key areas: improved awareness, earlier diagnosis and intervention, and a higher quality of care.

3.3.2 Legislation

- The Mental Health Act 1983 (amended by the Mental Health Act 2007) governs the involuntary admission, treatment and detention of people in mental health inpatient settings. The Act also covers discharge from inpatient mental health settings. Section 117 entitles people to free aftercare when they are discharged from hospital under certain sections of the Act.
- The NHS and Community Care (NHSCC) Act 1990 covers the support of people receiving voluntary treatment in an inpatient setting. It requires health and local authorities to put in place arrangements for the care and treatment of people with a mental health problem in the community.
- The Children Act 1989, supplemented by the Children Act 2004, stipulates that all organisations working with children have a duty to safeguard and promote their welfare. Section 25 of the 2004 Act sets out the provisions under which a child who is being looked after by the local authority can be placed in secure accommodation.
- The Care Act 2014 introduces new legislation to make social care more personalised, fairer across the country and more supportive of carers. It seeks to ensure that people's wellbeing and the outcomes that matter to them are at the heart of every decision made. Provisions of the Act relevant to transitions between inpatient mental health settings and the community include a new right to advocacy to help people navigate the care and support system and the introduction of a specific definition of 'after care services'.
- Other policy and legislation relevant to this guideline, includes:

- Caring for our future: reforming care and support (Department of Health)
- Health and Social Care Act
- The Mental Capacity Act
- Children and Families Act.

4 What the guideline will cover

This guideline will be developed according to the processes and methods outlined in Developing NICE guidelines: the manual. This scope defines exactly what this guideline will (and will not) examine and what the guideline developers will consider.

The guideline will cover all people in transition between inpatient mental health settings and community or care home settings. The guideline will cover both admission to and discharge from inpatient mental health settings.

4.1 Who is the focus?

4.1.1 Groups that will be covered

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

Protected characteristics under the Equality Act 2010 were considered throughout the development of the scope and an equality impact assessment was undertaken.

4.1.2 Groups that will not be covered

- People moving between inpatient mental health settings (for example from a medium secure to a low secure bed).
- People moving between prison or a young offenders' institution and an inpatient mental health setting.
- People moving between prison or a young offenders' institution and a community or care home setting.

- Children and young people moving from children's to adult services unless a transition between an inpatient mental health setting and a community or care home setting is also involved.

4.2 Settings

4.2.1 Settings that will be covered

- Inpatient mental health settings:
  - All adult inpatient mental health settings (including secure settings).
  - All older people's mental health inpatient settings (including specialist dementia units in mental health inpatient settings).
  - All children's inpatient mental health inpatient settings, including tier 4 CAMHS, secure mental health settings for children and young people and specialist autism units.
  - Specialist units for people with mental health problems and additional needs such as a learning disability, hearing impairment or eating disorder.
- Care home settings
  - All residential and nursing care homes, including hospices.
  - Care homes for children (including secure children's homes)
- Community settings, including:
  - People's own homes and other housing, including temporary accommodation.
  - Foster care
  - Extra care housing (such as warden-supported, sheltered or specialist accommodation).
  - Shared Lives Scheme (formerly Adult Placement Scheme) living arrangements.
  - Supported living.

4.2.2 Settings that will not be covered

- General inpatient hospital settings.
- Non-inpatient health settings (including A&E and outpatients)

- Prisons and young offender institutions
- Police cells

4.3 Activities

4.3.1 Key areas and issues that will be covered

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

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

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

c) Coordination of care and joint working between mental health, social care and primary care and, where appropriate, housing and education. This will include service models of joint working (including joint provision) and communication and information sharing.

d) The effectiveness of components of care packages in supporting effective and timely transitions between inpatient mental settings and community or care home settings. This will include as a minimum:

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

psychotherapy, cognitive behavioural therapy, counselling and peer support
- voluntary and community sector support, including individual mental health volunteers
- housing support to enable discharge from inpatient mental health settings (including repairs and adaptations)
- employment support

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

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

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

4.3.2 Areas and issues that will not be covered

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

b) Admission avoidance. This is a much broader topic and is outside of the scope of this guideline.

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

d) Clinical effectiveness of crisis resolution, social, emotional and practical support (this may include occupational therapy,

psychotherapy, cognitive behavioural therapy, counselling and peer support). Where these interventions are in scope the focus will be on whether they work in supporting effective and timely transitions.

e) Transition between general inpatient hospital settings and community or care home settings. The experience of adults moving between general hospital settings and the community or a care home will be covered in a separate NICE guideline (Transition between inpatient hospital settings and community of care home settings for adults with social care needs).

4.4 Main outcomes

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

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

Service outcomes include:

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

- hospital readmissions.

4.5 Review questions

Review questions guide a systematic review of the literature. They address only the key issues covered in the scope and usually relate to interventions, service delivery or the experiences of people using services and their carers. The review questions will be used to explore evidence to consider how the outcomes which are important to people using services and their carers (listed in section 4.4) can be improved. Some possible review questions are:

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

4.5.2 What are the views of health, social care and other practitioners (for example housing and education), about the transition between inpatient mental health settings and community or care home settings?

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

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

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

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

4.5.7 What is the effect of specific interventions to support people living with dementia during transition between inpatient mental health settings and community or care home settings?

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

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

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

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

4.6 Economic aspects

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

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

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

4.7 Status of this document

4.7.1 Scope

This is the final the scope, incorporating comments from a 4-week consultation.

4.7.2 Timing

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

5 Related NICE guidance

5.1 Published NICE guidance

- Managing medicines in care homes NICE guideline SG1 (2014)
- Psychosis and schizophrenia in children and young people NICE guideline CG155 (2013)
- Patient experience in adult NHS services NICE guideline CG138 (2012)
- Improving the experience of care for people using adult NHS mental health services NICE guideline CG136 (2011)
- Rehabilitation after critical illness NICE guideline CG83 (2009)
- Mental wellbeing in older people NICE guideline PH16 (2008)
- Dementia NICE guideline CG42 (2006)

5.2 Guidance under development

NICE is currently developing the following related guidance:

- Home care NICE guideline, publication expected July 2015

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

6 Further information

Information on the guideline development process is provided in Developing NICE guidelines: the manual. Information on the progress of the guideline will also be available on the NICE website.

7 References

Byford, S., Sharac, J., Lloyd-Evans, B., Gilburt, H., Osborn, D., Leese, M., Johnson, S. and Slade, M. (2010) Alternatives to standard acute in-patient care in England: readmissions, service use and cost after discharge. British Journal of Psychiatry 197: s20–s25

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

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

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

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