NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Transition between inpatient mental health settings and community and care homes

Date of quality standards advisory committee post-consultation meeting:
4 May 2017.

2 Introduction

The draft quality standard for transition between inpatient mental health settings and community and care homes was made available on the NICE website for a 4-week public consultation period between 10 March and 7 April 2017. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 10 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 and 2.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

4. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Stakeholders were also invited to respond to the following statement specific questions:

1. For draft quality statement 2: NICE guideline NG53 recommends that out of area placements should be reviewed at least every 3 months. Given the intention to eliminate out of area placements for acute inpatient mental health care by no later than 2020/21 as part of the 5 year forward view, can you suggest a time frame that would help improve the quality of care for people in out of area placements and move towards achieving this?

2. For draft quality statement 4: NICE guideline NG53 recommends that everyone discharged from an inpatient mental health setting should have a follow-up within 7 days, or within 48 hours if a risk of suicide is identified at preparation for discharge. How would risk of suicide be identified to support measurement of a quality statement?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- The draft quality standard statements focus on areas that will support quality improvement.
- Mixed views about the inclusion of children and young people. Generally this was seen as positive, although one stakeholder considered that there should be a separate quality standard solely covering children and young people.
- Concern that the draft quality standard is not sufficiently person-centred, and does not include personalised support systems for people with additional needs, including support following discharge from hospital.

Consultation comments on data collection

- There are systems in place to collect data for the quality measures.
- There is insufficient focus on qualitative data in the outcome measures, including quality of life.

Consultation comments on resource impact

- Local advocacy services should be mapped and resources potentially pooled/collaboration opportunities identified. Non-statutory advocacy should be referenced, as funding has been reduced or ended in many areas.
- There are training requirements around approaches to sharing information and promoting advocacy services.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

People admitted to an inpatient mental health setting have access to advocacy services.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- The statement should explicitly reference that some people will transition into an inpatient mental health setting from a social care setting.
- There should be better clarification between the roles of parent, carer and advocate.
- There should be reference to a range of advocacy approaches, including non-statutory advocacy in view of reduction or removal of funding.
- The way people are signposted to advocacy services, and explanations given about these need to meet the needs of different people within the setting.
- Children, young people and families require information about services at different points, rather than just on admission.

- Hospital admission protocols are unlikely to provide evidence that advocacy services are promoted on admission.

5.2 Draft statement 2

People admitted to inpatient mental health settings outside the area in which they live have regular reviews of their placement.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Social care providers who have provided care for people in the past, or that will support people following discharge from an inpatient mental health setting should be included in placement reviews.
- Face--to-face reviews are preferable because it is less likely that safeguarding disclosures will be made over skype/telephone.
- There are financial implications in developing expert capacity in each locality for the range of mental health services, but there is potential for premature discharge from placements if there is insufficient expert capacity.

Consultation question 5

Stakeholders made the following comments in relation to consultation question 5:

- If a person is admitted to an out-of-area inpatient unit, a mental health professional from their local mental health service should make contact with them within the first 72 hours after admission, and at least weekly thereafter.
- Three months is a long time to be placed out of area.
- A discharge plan should be completed within 4 weeks of admission and progress towards its achievement reviewed every 3 months.

5.3 Draft statement 3

People discharged from an inpatient mental health setting have their care plan sent to everyone identified in the plan as involved in their ongoing care within 24 hours.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- The statement is difficult to implement for many patients whose admission lasts less than 7 days, but this group are most at risk of dying by suicide.
- Care plans should be received by those involved in ongoing care at the earliest opportunity. This will be impacted upon by the method of sharing.
- Social care providers should be involved in drawing up care plans.
- Test results, plans for communication, friendships and relationships, family issues, vulnerability issues such as safeguarding issues or disputes, and independent advocacy services suggested as items that should be explicitly referenced in the definition of the care plan.
- Care plans should include support that will be provided by allied health professionals.
- Involvement of people in development of their own care plan should form part of the quality measures for the statement. However, there are situations where it might not be possible to fully involve people in developing their care plan, or automatically share the plan with them.
- There should be clear and appropriate methods of involvement for children and young people, in line with the UN Convention on the Rights of the Child.

5.4 Draft statement 4

People discharged from an inpatient mental health setting are followed up within 48 hours if a risk of suicide has been identified.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness and the Health Select Committee recommend much earlier follow-up of all people discharged from an inpatient mental health setting than within 7 days.
- Groups of people who might be at a higher risk of suicide include people who live alone, people who have alcohol or drug problems, and males aged between 50-64.
- People with complex mental health disorders or personality disorder often receive inappropriate follow up for severe distress when there is an apparent suicide risk.

- Drug & alcohol teams often do not have capacity to “pick people up” within 48 hours. People discharged from a mental health setting following treatment from a drug and alcohol team should receive follow-up care from the same team in the community.
- Children, young people and families require a single point of contact that they can contact by phone, text or email.
- The equality and diversity considerations section should be reworded, so it does not appear to suggest that prevention of homelessness is solely to support ease of follow-up.

Consultation question 6

Stakeholders made the following comments in relation to consultation question 6:

- If there is a major risk of suicide, people should not be discharged, but if the threshold is set much lower, it will apply to almost everyone being discharged.
- Given the vulnerability of all people discharged from an inpatient mental health setting, follow-up within 7 days for those without an “identified risk of suicide” is too-long a timeframe.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Reintegration to education or vocation.
- Contact with addictions teams if the patient has an identified addictions disorder.
- Communication between the primary care team/GP practice and the mental health team before and during admission, including 24 hour access to the key mental health worker to discuss urgent problems.
- Support requirements of people with learning disabilities and/or autism who display behaviour that challenges including those with a mental health condition, particularly NHS England’s programme of care and treatment reviews.

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	*Organisation name*	Statement No	Comments Please insert each new comment in a new row
1	British Institute of Learning Disabilities	General	Our response to this quality standard will focus on the requirements of people with learning disabilities and or autism who are accessing inpatient mental health settings.
2	British Institute of Learning Disabilities	General	We appreciate that this quality standard sets out to ensure that the transitions between mental health hospitals and people's own homes, care homes or other community settings address individual needs. However, there appears to be no links to or learning from the Building the Right Support programme (LGA,ADASS, NHS England October 2016) which includes a National Service Model. This work addresses the support required by people with learning disabilities and/or autism who display behaviour that challenges including those with a mental health condition. In particular, NHS England has rolled out a programme of Care and Treatment Reviews to prevent unnecessary admissions and avoid lengthy stays in hospital. These reviews involve the individual, their families/carers, independent expert advisors (one clinical and one expert by experience) and the responsible commissioner and those involved in the person's care and treatment. These reviews focus on whether an individual's care is safe and effective and whether they need to be in hospital as well as whether there is a plan for their future discharge and support in the community.
3	British Institute of Learning Disabilities	General	We believe that the Quality standard does not provide sufficient emphasis on ways of engaging with the individual and their family and does not emphasise the change in culture that is required to ensure that the hospital stay and transition to discharge is person centred. There is an understandable emphasis on the collection of quantative data but little direction about how to focus on outcomes that identify quality of life issues and other qualitative information.
4	Mind	General	All the elements of guideline NG53 are important, but this looks to be a fair selection of standards.
5	Royal College of General Practitioners	General	• The QS include children & young people as well as adults. The inclusion is relevant and good. • This is a sensible and pragmatic document and the aims admirable. Statement 3 in particular supports good integration of care between primary & secondary care. • The communication and interaction between the Primary Care Team/GP practice and the Mental Health Team is crucial before admission, during admission and after discharge by e-mail/telephone. • The GP team needs to be able to have 24 hour access to the key Mental health worker to discuss urgent problems e.g. suicidal attempts, Section orders, domiciliary visits.

ID	*Organisation name*	Statement No	Comments Please insert each new comment in a new row
			• The web of information, interaction, shared information, agreed plan and shared risk taking is considerable and will include-The family, carer, spouse-Housing, Social Services and welfare agencies/benefits-The importance of the Voluntary sector and on occasion the Private sector must also be considered. The Case Conference, easier with videoconferencing is an effective method with an impressive track record.
6	Royal College of Paediatrics and Child Health	General	Question 1: see our comments above Question 2: not within our expertise Question 3: not within our expertise Question 4: - Identification of local advocacy services and if the contract takes into account children and young people requiring support due to mental health conditions or during the transition between inpatient to community settings - Additional training to support staff in better understanding different communication needs and approaches to sharing information – reference to the NHS Accessibility Information Standard (see guidance) - Advocacy / training / support services can be achieved by a pooled resource system by effectively mapping the local offer and identifying existing opportunities for collaboration Question 5: not within our expertise Question 6: not within our expertise
7	Royal College of Paediatrics and Child Health	General	Our reviewers recognise that this guidance includes children and young people; however, children and young people are by definition a vulnerable group and require special provision to ensure their safety and well-being. Therefore, they would strongly advise that consideration is given to developing guidance on transition from inpatient mental health facilities to community for children and young people only. In addition, ask to cross reference to the NICE guidelines on Patient Experience in adult NHS in services as well as Transition from children's services to adult services for key learning and principles.
8	Royal College of Paediatrics and Child Health	General	Whilst the draft guidelines include 'children, young and adults', our reviewers would advise a clearer more overt definition of what age range is meant by 'children' and 'young people'. This would be useful to avoid any confusion, inconsistencies and possible gaps.
9	Royal College of Psychiatrists	General	There should be a consideration to include the reintegration to education or vocation.
10	Royal College of Psychiatrists	General	There is no mention of the impact of addictions or management of the transition. There should be specific mention of contacting addictions teams if the patient has an identified addictions disorder.

ID	*Organisation name*	Statement No	Comments Please insert each new comment in a new row
			In particular, if the patient has completed a detoxification or started opioid substitution pharmacological treatment, the addictions service should be contacted in advance and prior to discharge. It would be too late to make contact after discharge.
11	British Institute of Learning Disabilities	1	It is important that this statement refers to access to non-statutory advocacy as funding for this has been reduced or ended in many areas. There should be reference to a range of advocacy approaches not just issue based advocacy. Many local self-advocacy organisations can provide group support which can provide social contact in the community and an early warning system if any individual starts to become unwell. Clear information in a range of accessible formats about the advocacy available and how it works should be available. Hospital admission protocols are unlikely to provide evidence that advocacy services are promoted on admission. Hospital staff will need awareness training about advocacy to enable them to promote the service. In terms of equality and diversity considerations, the draft says "advocacy services should take into account….." and we think this should be strengthened to "must address….."
12	Mind	1	We welcome and strongly agree with this standard of making advocacy services available to people admitted to an inpatient mental health setting. This should make a significant difference to people's experience and their ability to know and understand their rights. It should support people's involvement in their own discharge and care planning and hence improve the quality and appropriateness of the plans.
13	Mind	1	Appropriately tailored advocacy services could make a significant difference in addressing inequalities in inpatient settings. We recommend strengthening the statement on page 6 by adding, "and be equally accessible to the mix of people in inpatient settings".
14	Real Life Options	1	As an external 'service provider' it can be very difficult to ensure that an individual we are supporting has access to advocacy services. We are very supportive of this statement as it will give us increased authority to ensure that this requirement is met. We would like to see the statement more explicitly recognise that that some people will be entering a mental health setting having been supported in a social care setting. We have had experience of not being able to hand over as comprehensively as we would want. We have also had excellent experience where we have been able to work very closely with the mental health setting which has enabled a very positive outcome as an individual has transferred.
15	Royal College of General Practitioners	1	• There needs to be clarification between the roles of parent, carer and advocate. This means a separate person from the parent or carer (in Scotland this is in safeguarding law for children & young people?). It is a very fine balance for that advocate and there are insufficient resources at the moment to fulfil this obligation.

ID	*Organisation name*	Statement No	Comments Please insert each new comment in a new row
16	Royal College of Paediatrics and Child Health	1	Children, young people and families have told us that they need to be informed of services at different points in time not just on one occasion (Reference: &Us ® RCPCH Voice Bank 2016)
17	Royal College of Paediatrics and Child Health	1	Our reviewers indicate that it is not sufficient to assume that the people will have understood what an advocacy service is (e.g. handing a leaflet to a patient), therefore they would advise this is adequately explained to make sure they have understood the concept to be able to make an informed decision as to whether they then take up the service offered.
18	Royal College of Paediatrics and Child Health	1	It is not only the responsibility of advocacy services to ensure equality and diversity, it is everyone's responsibility. The people doing the signposting or referral to advocacy need to also do this in a way that is accessible and meets the needs of children and young people.
19	NHS England	2	If a person has been admitted to an out-of-area inpatient unit, a mental health professional from the person's local mental health services should make direct contact with the person within the first 72 hours after admission, and at least weekly thereafter.
20	British Institute of Learning Disabilities	2	We think that a discharge plan should be completed within 4 weeks of admission and progress to achieving this should be reviewed every 3 months.
21	Mental Health Specialist Group of the British Dietetic Association	2	We feel that 3 months is a long time to be placed "out of area" for an inpatient admission and that consideration should be made to reduce this further. If a person needs a lengthy admission, they are amongst the most unwell and staying away from local area and family for an extended period of time may make the recovery process more difficult/ prolonged
22	Mind	2	While clearly the goal must be to end out-of-area acute inpatient placements, for as long as they take place it will be important to have reviews and we agree with this standard. People who have more specialist placements that may need to be out of area (and so continue to occur into the future) should also have reviews and the other benefits of contact with their home team.
23	Real Life Options	2	Former social care providers, or providers who are to provide support following discharge from a mental health setting need to be included in regular reviews if at all possible. We support this standard but believe that there should be scope for a social care service provider to be considered, if appropriate, as part of the review process.
24	Royal College of General Practitioners	2	• A face to face review by a trusted person is preferable to a Skype review because it is unlikely that safeguarding disclosures will be made by distance. People who are removed from their normal context and some way from their contacts and family can be abused by those meant to be caring for them.

ID	*Organisation name*	Statement No	Comments Please insert each new comment in a new row
			• On the other hand, there are significant financial implications for the development of expert capacity in each locality for the range of mental health services – for example those with eating disorders or complex mental health difficulties including those given the diagnosis of Personality Disorder. There is a potential of a "dumbing down" of services and early discharges which have safeguarding and deaths by suicide risks.
25	British Institute of Learning Disabilities	3	Whilst appreciating the importance of all those involved having a care plan at discharge, we would want the emphasis to be on its delivery. In relation to the quality statement for different audiences, it would be good if the care plans could be described as being "person centred." In the definition of the care plan we would want social networks to include "friendships and relationships" and any family issues. It would be helpful to identify any known vulnerabilities such as hate crime, sexual exploitation and online grooming, neighbour disputes with clear plans to address these issues.
26	East Midlands Academic health science network Patient safety collaborative	3	Agree with this statement but think the need to emphasise communication plan and test results which are part of general discharge procedure should be made more explicit within the care plan.
27	Mental Health Specialist Group of the British Dietetic Association	3	I support the idea, but in practical terms the care plan might be sent out within 24hours e.g. by post, but unless trusts / professional involved are on the same computer system, the care plans are unlikely to be received by all involved within that 24hour period, therefore potentially increasing risk.
28	Mental Health Specialist Group of the British Dietetic Association	3	Discharge documentation should include consideration of AHPs as appropriate who are involved in a person's care. These members of the team often provide significant input on the ward and ongoing review following discharge into the community but are rarely included in any such correspondence. AHPs are often involved soon after discharge or in the transition from hospital to the community therefore it is imperative that they also have this information in relation to risks available at the earliest opportunity.
29	Mind	3	There is a clear safety rationale in the briefing paper for communicating the care plan to all those involved in it within 24 hours of discharge. We welcome the reference to people being fully involved in developing their care plan but note that this does not form part of the measure. We recommend that evidence of involvement in care planning is included in measuring this standard. A less satisfactory alternative would be to include people's experience of involvement in care planning in the outcome measure (experience of discharge).

ID	*Organisation name*	Statement No	Comments Please insert each new comment in a new row
30	NHS Improvement	3	This statement focusses on the care plan as being the main resource for communication at discharge. In NHS England in August 2014 we issued a patient safety alert on risks arising from breakdown and failure to act on communication during handover at the time of discharge from secondary care https://www.england.nhs.uk/2014/08/psa-communication/ As part of this work programme we developed standards on the communication of patient diagnostic test results on discharge from hospital https://www.england.nhs.uk/patientsafety/discharge/. These standards had input from mental health experts and are relevant to patients discharged from mental health settings. This current statement doesn't make any reference to the communication of test results within the care plan or discharge summary
31	Real Life Options	3	We are supportive of this statement, however we believe that the care plan would need to be drawn up in conjunction with a social care support provider as soon as possible and this should be established before discharge.
32	Royal College of General Practitioners	3	• This QS is difficult to implement for many patients whose admission lasts less than 7 days and are also most at risk of dying by suicide (National Confidential Enquiry 2014). • The care plan needs to go with the patient and with permission shared with the carer as well as health & social care personnel by email of fax, not by second class mail. • Discharge medications always seem to be problematic. The pharmacist and GP need to know the same day and how much medication the patient was discharged with, whether in blister packs, whether to be dispensed by the GP or at the follow-up specialist appointment.
33	Royal College of Paediatrics and Child Health	3	Our reviewers would recommend that 'independent advocacy services' are added to the list of bullet points
34	Royal College of Paediatrics and Child Health	3	Our reviewers are concerned that it may not always be appropriate to automatically share a care plan with every child or young person and consideration needs to be given to their level of mental capacity in being able to understand the information and being adequately supported. The UNCRC (United Nations Convention on the Rights of the Child 1989) is clear that the right for children and young people to be involved/consulted in decisions that affect them is across all ages, with article 23 referencing specifically those with disabilities or additional needs to also be involved.

ID	*Organisation name*	Statement No	Comments Please insert each new comment in a new row
			This needs to be made more explicitly clear in the wording of recommendations (see some examples noted below) on how the recommendation meets this duty when only referencing without further reference to appropriate methods. & Us® RCPCH Voice Bank 2016 evidence from children, young people and families: - Need to ensure that information shared is age appropriate, visual and that there are copies provided for children, young people and families. - A key worker is an idea that has been raised from parents/carers and young people in our Long Term Conditions consultation in 2016
35	Royal College of General Practitioners	3 / 4	• Those who live alone, have alcohol or drug problems, are men between 50 – 64 need to be targeted as at particular risk of dying by suicide. The discharge address (if going to stay with a relative or friend) must be double checked as for maternity patients. If maternity patients can be visited or contacted the same day, we should aim to do the same for these patients. Continuity of non medical staff (recommended in the National Confidential enquiry) could help with this.
36	British Institute of Learning Disabilities	4	We agree with the importance of identifying any suicide risk which can be addressed as part of the planning for discharge.
37	Mind	4	We welcome attention to the timing of follow-up which, as indicated, is an important suicide prevention measure. However we are concerned that follow-up within 48 hours is limited to people with an identified suicide risk, and that the guideline recommends follow-up within seven days for everyone else. Since the development of the guideline, the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) have highlighted the urgent need for much earlier follow-up than seven days for inpatients discharged from mental healthcare and this has been recommended by the Health Select Committee as well. Clearly mental health practitioners need to identify suicide risk as far as possible and people who have had a suicide risk identified will need early follow-up and for their discharge and subsequent care and support to be planned in accordance with their level of risk. However, everyone admitted to a mental health ward is seriously unwell and is likely to be very vulnerable in the post-discharge period. Seven days is too long to wait for people whose recovery is still at risk and we are asking that everyone is followed up within 48 hours after leaving inpatient care.

ID	*Organisation name*	Statement No	Comments Please insert each new comment in a new row
			Rather than identify a way of identifying suicide risk for the purpose of this standard, we recommend assuming there is risk and following up everyone within 48 hours. This does not affect the requirement for practitioners to understand the needs of the people they are working with as fully as possible and tailor support to meet them.
38	Mind	4	The statement on homelessness is logical in this context but reads oddly - as though the reason for preventing homeless is to facilitate follow-up. All attention on preventing and addressing homelessness within discharge planning and follow up care is very welcome and important but we suggest reconsidering how it is presented here.
39	Royal College of General Practitioners	4	• This statement is challenging, because of the difficulty of assessing 'risk of suicide'. On one hand if there is a major risk of suicide, surely patients should not be being discharged. On the other hand, if the threshold is set much lower, then it might apply to almost every patient being discharged, certainly all admitted because of severe depression. Without any agreement how to measure risk, or where to set the threshold the quality statement degenerates into a vague aspiration. • People with complex mental health difficulties or with the diagnosis of Personality Disorder are often the most poorly served because of their being seen to be "demanding" and "unstable". The Police service maybe the ones called out repeatedly for severe distress when there seems to be a suicidal risk. They have more professionalism than some inexpert CRHT who have been known to tell the person "to get on with it then" or "stop wasting our time". If the ambulance or police are called within 48 hrs of discharge then there must be a mental health hub red alert. • Drug & alcohol teams often do not have capacity to "pick people up" within 48hrs. Those who have been inpatients need seamless care from being seen as an inpatient to care by the same team in the community. • It may be important to check that the patient does not have medication hoarded at home before discharge. There may be other suicide prevention actions which communities could make and not only health or social care staff.
40	Royal College of Paediatrics and Child Health	4	Children, young people and families have told us they need a single point of contact that they can access instantly by phone, text, email through good signposting and relevant timescale. (&Us ® RCPCH 2016 Voice Bank).

Registered stakeholders who submitted comments at consultation

- British Dietetic Association
- British Institute of Learning Disabilities
- East Midlands Academic health science network
- Mind
- NHS improvement
- Royall college of paediatrics and child health
- Royal college of general practitioners
- Royal college of psychiatrists
- Real Life Options