NICE National Institute for Health and Care Excellence

NICE quality standard

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

Quality standard

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Contents

This standard is based on NG53.

This standard should be read in conjunction with QS142, QS136 and QS34.

Quality statements

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Statement 2 People admitted to specialist inpatient mental health settings outside the area in which they live have a review of their placement at least every 3 months.

Statement 3 People discharged from an inpatient mental health setting have their care plan sent within 24 hours to everyone identified in the plan as involved in their ongoing care.

Statement 4 People who have a risk of suicide identified at preparation for discharge from an inpatient mental health setting are followed up within 48 hours of being discharged.

NICE has developed guidance and a quality standard on service user experience in adult mental health services (see the NICE pathway on service user experience in adult mental health services), which should be considered alongside these quality statements.

Other quality standards that should be considered when commissioning or providing services for people who are moving between inpatient mental health settings and community or care home settings include:

- Learning disabilities: identifying and managing mental health problems (2017) NICE quality standard 142
- Transition between inpatient hospital settings and community or care home settings for adults with social care needs (2016) NICE quality standard 136
- Self-harm (2013) NICE quality standard 34.

A full list of NICE quality standards is available from the quality standards topic library.

Quality statement 1: Access to independent advocacy services

Quality statement

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

Rationale

Having an advocate helps people to make their views and wishes heard. It is important that people are told about independent advocacy services on admission to an inpatient mental health setting, and can access them throughout their stay, so that they can be involved in decisions about their care.

Quality measures

Structure

a) Evidence of local arrangements to provide independent advocacy services for people admitted to an inpatient mental health setting.

Data source: Local data collection, for example, service level agreements with local advocacy service providers and hospital admission checklists.

b) Evidence of local arrangements to promote independent advocacy services to people admitted to an inpatient mental health setting.

Data source: Local data collection, for example, admission checklists.

Process

Proportion of admissions to an inpatient mental health setting for which information is provided on admission about support available from independent advocacy services.

Numerator – the number in the denominator for which information is provided on admission about support available from independent advocacy services.

Denominator – the number of admissions to an inpatient mental health setting.

Data source: Local data collection, for example, an audit of case notes.

Outcome

Level of satisfaction with access to independent advocacy services for people using inpatient mental health settings.

Data source:Local data collection, for example, local patient surveys.

What the quality statement means for different audiences

Service providers (inpatient mental health services) ensure that independent advocacy services are available to people on admission. Staff know how to signpost people to independent advocacy services at admission or at any point during their stay in a way that takes account of individual needs and preferences.

Health and social care practitioners (the admitting team) discuss independent advocacy services with people on admission to an inpatient mental health setting and tell them how to access services if and when they want to.

Commissioners (local authorities) ensure that they commission adequate independent advocacy services and that access to independent advocacy is set out in contracting arrangements with providers so that people admitted to an inpatient mental health setting have access to independent advocacy services on admission and during their stay.

People who are admitted to hospital for a mental health problem are told how they can get support from an independent advocacy service, if they want to. An independent advocate can help people get the information they need to make choices about their care and can help them to get their views across.

Source guidance

Transition between inpatient mental health settings and community or care home settings (2016) NICE guideline NG53, recommendation 1.3.4

Definitions of terms used in this quality statement

Independent advocacy services

Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy schemes work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and social justice.

Independent advocacy services include, but are not limited to:

- independent mental health advocates provided under the Mental Health Act 1983
- independent mental capacity advocates provided under the Mental Capacity Act 2005
- relevant local user groups
- charitable organisations.

[Adapted from Action for Advocacy, About Advocacy and the Mental Health Act 1983 Section 130A Independent mental health advocates]

Equality and diversity considerations

Independent advocacy services, and information provided about them, should take into account people's language and communication needs, cultural and social needs, and other protected characteristics.

Quality statement 2: Out-of-area admissions

Quality statement

People admitted to specialist inpatient mental health settings outside the area in which they live have a review of their placement at least every 3 months.

Rationale

People should be treated for a mental health problem in a location that helps them to retain the contact they want with family, carers and friends, and to feel as familiar as possible with the local environment. If people with a non-acute mental health problem are admitted to a specialist inpatient mental health setting outside the area in which they live, they are particularly vulnerable to delayed discharges because case management and assessment of readiness for discharge is more difficult to deliver. When people are placed outside of the area in which they live, named practitioners from the person's home area and the inpatient ward can work together to ensure the placement is reviewed regularly, so that it does not last longer than necessary.

Quality measures

Structure

a) Evidence of local arrangements to monitor the length of placements of people admitted to a specialist inpatient mental health setting outside the area in which they live.

Data source: Local data collection, for example, identification systems.

b) Evidence of local arrangements to review placements at least every 3 months for people in an out-of-area placement in a specialist inpatient mental health setting.

Data source: Local data collection, for example, review protocols.

Process

Proportion of out-of-area placements in specialist inpatient mental health settings for which there is a review of the placement at least every 3 months.

Numerator – the number in the denominator for which there is a review of the placement at least every 3 months.

Denominator – the number of out-of-area placements in specialist inpatient mental health settings lasting longer than 3 months.

Data source: Local data collection, for example, from hospital patient records.

Outcome

a) Number of active out-of-area placements in specialist inpatient mental health settings.

*Data source:*Local data collection.

b) Length of stay in out-of-area placements in specialist inpatient mental health settings.

*Data source:*Local data collection.

What the quality statement means for different audiences

Service providers (specialist inpatient mental health services, such as those in high-dependence units or specialised rehabilitation units within the NHS or independent services) ensure that they work together to monitor the length of placements for people in an out-of-area placement in an inpatient mental health setting, so that named practitioners from the inpatient ward and the person's home area can review the placement at least every 3 months.

Health and social care practitioners (a named practitioner from the person's home area and a named practitioner from the ward) work together to monitor the length of placements of people admitted to specialist inpatient mental health settings outside the area in which they live and review these at least every 3 months.

Commissioners (clinical commissioning groups) ensure that placements are monitored and reviewed at least every 3 months when people are admitted to specialist inpatient mental health settings outside the area.

People who are admitted to a specialist mental health hospital outside the area where they live have a review of how their placement is going at least once every 3 months, to make sure they are not kept in hospital for longer than they need to be. This is carried out jointly by a person from the hospital ward and someone from their home area involved in their care.

Source guidance

Transition between inpatient mental health settings and community or care home settings (2016) NICE guideline NG53, recommendation 1.3.11

Definitions of terms used in this quality statement

Placement review

Named practitioners from the person's home area and the inpatient ward should work together to ensure that the person's current placement lasts no longer than required. Review should be carried out either in person or by audio or videoconference.

[NICE's guideline on transition between inpatient mental health settings and community or care home settings, recommendation 1.3.11.]

Specialist inpatient mental health setting outside the area in which the person lives

In this quality statement, a specialist mental health inpatient setting refers to an inpatient unit that provides non-acute complex care and does not form part of the usual local network of services. This means that it does not usually admit people living in the catchment of the person's local community mental health service and is somewhere the person cannot be visited regularly by their care coordinator to ensure continuity of care and effective discharge planning. Sending providers are to determine if a placement is classed as an out-of-area placement.

Examples of specialist mental health inpatient settings include high-dependence units or specialised rehabilitation units within the NHS or independent services. People admitted to specialist inpatient settings will often have multiple mental health problems.

[Adapted from NHS England's definition of out of area placements in mental health services for adults in acute inpatient care]

Quality statement 3: Communication on discharge

Quality statement

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

Rationale

Sharing a person's care plan with people who will be involved in their ongoing care (as agreed by the person and their families or carers, and identified in their care plan) at the point at which they are discharged from inpatient mental health settings helps to make sure agreed plans are received as early as possible, so that they can be carried out and treatment continued. This reduces the risk of avoidable harm to the person, as well as avoidable readmissions.

Quality measures

Structure

a) Evidence of local arrangements to develop care plans that detail who will be involved in providing ongoing care to people discharged from an inpatient mental health setting.

Data source: Local data collection, for example, care planning protocols.

b) Evidence of local arrangements to send within 24 hours, the care plans of people discharged from an inpatient mental health setting to everyone identified in it as involved in their ongoing care.

Data source: Local data collection, for example, hospital discharge protocols.

Process

Proportion of discharges from an inpatient mental health setting where the person's care plan is sent within 24 hours to everyone identified in it as involved in their ongoing care.

Numerator – the number in the denominator in which the person's care plan is sent within 24 hours to everyone identified in it as involved in their ongoing care.

Denominator – the number of discharges from an inpatient mental health setting.

Data source: Local data collection, for example, a review of patient notes.

Outcome

a) Level of satisfaction with support following discharge from inpatient mental health settings.

*Data source:*Local data collection, for example, local patient surveys.

b) Readmissions to inpatient mental health services within 30 days of discharge.

*Data source:*Data on unplanned readmissions to mental health services within 30 days of a mental health inpatient discharge in people aged 17 and over are available from the NHS Digital Indicator Portal as part of the clinical commissioning group outcomes indicator set – indicator 3.16.

What the quality statement means for different audiences

Service providers (inpatient mental health services) ensure that staff receive training on how to develop care plans, and how to share them so that people involved in care to receive them as early as possible. They have protocols in place to ensure that plans are developed at the earliest opportunity after admission, and shared in a way that allows quickest receipt following discharge, including for people whose admission lasts less than 7 days.

Healthcare practitioners (mental health practitioners) work with people admitted to an inpatient mental health setting to identify people who will be involved in the person's care and send a copy of the care plan to them within 24 hours of their discharge, using the method of sharing that allows the plan to be received as early as possible. It is important that plans are developed at the earliest opportunity after admission, and shared following discharge, including for people whose admission lasts less than 7 days.

Commissioners (clinical commissioning groups and local authorities) ensure that care plans can be shared within and across health and social care services within 24 hours of people being discharged from an inpatient mental health setting.

People leaving hospital after inpatient treatment for a mental health problem have a care plan for staying as well as possible in future, that they have helped to put together. The plan includes their recovery goals, how to cope with symptoms, what to do in a crisis, their medicines and treatment, and any work, training, learning or social activities. Their mental health practitioner should make

sure a copy of this plan is sent within 24 hours of their discharge to everyone who will be involved in supporting them.

Source guidance

Transition between inpatient mental health settings and community or care home settings (2016) NICE guideline NG53, recommendation 1.6.3

Definitions of terms used in this quality statement

Care plan

A care plan for discharge from an inpatient mental health setting is based on the principles of recovery and describes the support arrangements for the person after they are discharged. It should include:

- discharge address
- possible relapse signs
- recovery goals
- who to contact
- where to go in a crisis
- budgeting and benefits
- handling personal budgets (if applicable)
- social networks
- educational, work-related and social activities
- details of medication
- details of treatment and support plan
- physical health needs including health promotion and information about contraception
- date of review of the care plan

- follow-up requirements following discharge, including method of communication for follow-up.

It is important that the process of care planning is person-centred and that people are involved in developing their own care plan (see quality statement 8 in the quality standard for service user experience in adult mental health services).

[NICE's guideline on transition between inpatient mental health settings and community or care home settings, recommendation 1.5.20 and expert opinion]

Everyone involved in a person's care

People involved in providing support to the person at discharge from an inpatient mental health setting and afterwards should be listed in the care plan. This is likely to include the person's GP, community mental health teams (including crisis teams), social workers and other local authority services, and carers.

[Adapted from NICE's guideline on transition between inpatient mental health settings and community or care home settings, recommendation 1.5.20 and expert opinion]

Equality and diversity considerations

In some cases, it might not be appropriate to fully involve people in developing their own care plan, or to share the plan with them, for example when a person lacks capacity. Independent advocates can represent people's interests and support them to obtain the services they need.

Quality statement 4: Suicide risk

Quality statement

People who have a risk of suicide identified at preparation for discharge from an inpatient mental health setting are followed up within 48 hours of being discharged.

Rationale

Mental health practitioners should assess people's risk of suicide when preparing for discharge. This will take into account the person's risk on admission to the unit, throughout their stay and when discharged into the community. Everyone discharged from an inpatient mental health setting should receive follow-up, which should be within 48 hours for people who have a suicide risk identified. Follow-up can help to identify any further support they may need, such as access to a crisis service or other community support.

Quality measures

Structure

a) Evidence of local arrangements to identify people at risk of suicide at preparation for discharge from an inpatient mental health setting and to record the risk for 48-hour follow-up.

b) Evidence of local arrangements to follow-up within 48 hours of discharge people who are identified as being at risk of suicide.

Data source: Local data collection, for example, hospital discharge protocols.

Process

Proportion of discharges from an inpatient mental health setting in which people are followed up within 48 hours of discharge if they are identified as being at risk of suicide.

Numerator – the number in the denominator followed up within 48 hours of discharge.

Denominator – the number of discharges from an inpatient mental health setting of people identified as being at risk of suicide.

Data source: Local data collection, for example, an audit of case notes or care plans.

Outcome

Number of suicides of people recently discharged from inpatient mental health settings.

Data source:National numbers of suicides within 3 months of inpatient discharge are published in the University of Manchester's National confidential inquiry into suicide and homicide by people with mental illness reports.

What the quality statement means for different audiences

Service providers (inpatient mental health settings) ensure that staff are trained to assess and monitor people's risk of suicide on admission to the unit, throughout their stay and when they are preparing for discharge into the community. They also ensure that staff are trained to follow-up people who are identified as being at risk of suicide within 48 hours of discharge, and that this follow up takes place.

Healthcare practitioners (mental health practitioners) work together to assess and monitor people's risk of suicide on admission to the unit, throughout their stay and when they are preparing for discharge into the community. They follow-up people within 48 hours of discharge from an inpatient mental health setting if they are identified as being at risk of suicide when preparing for discharge.

Commissioners (clinical commissioning groups) ensure that the services they commission have protocols in places to identify suicide risk throughout an admission and prior to discharge, and follow-up people at risk of suicide within 48 hours of discharge.

People leaving hospital after inpatient treatment for a mental health problem are contacted by someone from their care team to check how they are doing within 48 hours of their discharge, if the team are worried that they may be at risk of harming themselves.

Source guidance

Transition between inpatient mental health settings and community or care home settings (2016) NICE guideline NG53, recommendation 1.6.8

Definitions of terms used in this quality statement

Follow-up

The communication method used for follow-up should be agreed in the person's care plan.

Equality and diversity considerations

Follow-up may be more difficult for people who are homeless. This should be taken into account when considering discharge into the community. Housing needs should be discussed and arrangements for follow-up made before the person is discharged.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision making, choice, and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See quality standard advisory committees on the website for details of standing committee 1 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available on the quality standard's webpage.

This quality standard has been incorporated into the NICE pathway on transition between community or care home and inpatient mental health settings.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Improving outcomes

This quality standard is expected to contribute to improvements in the following outcomes:

- experience of hospital care for people staying in an inpatient mental health setting
- length of stay in inpatient mental health settings
- hospital readmissions within 30 days of discharge from an inpatient mental health setting
- delayed discharges from out-of-area placements in inpatient mental health settings
- suicide of people discharged from inpatient mental health settings.

It is also expected to support delivery of the Department of Health's outcome frameworks:

- Adult social care outcomes framework 2015–16
- NHS outcomes framework 2016–17
- Public health outcomes framework for England, 2016–19.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the resource impact statement for the NICE guideline on transition between inpatient mental health settings and community or care home settings to help estimate local costs.

Diversity, equality and language

During the development of this quality standard, equality issues were considered and equality assessments are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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Endorsing organisation

This quality standard has been endorsed by Department of Health, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Royal College of Nursing
- Mind
- Care England
- British Geriatrics Society
- Royal College of General Practitioners
- British Dietetic Association