Leaving hospital

Briefing on discharge from mental health inpatient services

mind
for better mental health

"I wish the discharge process was slower. It's weird because I miss hospital and all the staff and that's the hardest bit as well as the hospital and community not talking to each other which was hard. I also went from having 24-hour support to none till my next appointment."[1]

Introduction

Last year over 100,000 people in England spent time in hospital for a mental health problem. When you come out of hospital after a mental health crisis, whether you've been there for days, months or even years, you need the right care and support to help you recover and put your life back together. Guidance and standards from NICE set out how discharge from hospital should be planned, carried out and followed up. However, despite examples of excellent practice that show what can be done, we've heard from hundreds of people whose experience does not measure up.

This briefing is based on:

- NICE guidance and standards on discharge from hospital:
  - guideline on transitions between inpatient mental health settings and community or care home settings[2]
  - Quality Standard[3]
- good practice examples
- findings from our online survey of individuals' experiences of leaving hospital.[4]

Further guidance and support is expected from NHS England and the National Collaborating Centre for Mental Health in their work on an evidence-based acute mental health care pathway.[5]

Services under pressure

"In the first two months after discharge I had a social worker from the local mental health team. Many times he cancelled my appointment at short notice and he didn't say why. The team seem short of staff and he seems overworked. This has not been what I expected when discharged and has not helped me."

We know that NHS and local authority mental health services are under huge pressures, with growing demand, constrained finances and insufficient capacity, exacerbated by a lack of housing. Local Minds[6] feel this pressure too, seeing more people in crisis and with higher levels and complexity of need that, in some cases, go beyond their resources to support. Many local Mind services could provide support for people leaving hospital, but lack of notice and pre-discharge communication also make it difficult to provide a timely response.

The impact on people with mental health problems when they cannot get the support they need is "increasing vulnerability, sense of powerlessness, relapse into mental ill health including depression and anxiety".[7]

1 in 3 people
were discharged with less than 48 hours' notice

1. All quotes are from Mind's online survey of 1,221 people conducted between February and September 2017 unless stated otherwise.
2. National Institute for Health and Care Excellence (2016) Transitions between inpatient mental health settings and community or care home settings (NG53) https://www.nice.org.uk/guidance/ng53
3. National Institute for Health and Care Excellence (2017) Transitions between inpatient mental health settings and community or care home settings (QS159) https://www.nice.org.uk/guidance/qs159
4. Mind's online survey of 1,221 people conducted between February and September 2017.
5. See Resources section.
6. The Local Mind network consists of around 135 independent organisations throughout England and Wales providing mental health services that include talking therapies, peer support, advocacy, crisis care, employment and housing support.
7. Springfield Mind, Stratford-upon-Avon.

Discharge and care planning

"The community team kept in touch with me regularly while I was an inpatient. This helped me when I was discharged as they had been with me through the disruption of this particular hospital admission and were able to help me with anything that cropped up when home. I had and still have optimal support and feel completely involved in all my care."

Coproduced discharge planning

NICE guidance says to start discharge planning at admission or as early as possible when in crisis[8] and to do it collaboratively:

"Health and social care practitioners in the hospital and community should plan discharge with the person and their family, carers or advocate. They should ensure that it is collaborative, person-centred and suitably-paced, so the person does not feel their discharge is sudden or premature."[9]

Coproduced planning will give the person more confidence about leaving hospital and mean that the care plan meets their needs and wishes better.

Person-centred care planning: Rotherham, Doncaster and South Humber NHS Foundation Trust[10]

The Care Quality Commission rated this trust's crisis services outstanding, and drew attention to their patient-centred care, active promotion of advance decision-making, holistic planning of transitions and care plans that showed that patients' individual, cultural and religious beliefs were taken into account and respected.

Yet nearly a third of the people in our survey said they were not involved in planning their own care (31 per cent) and nearly a quarter (23 per cent) were unaware of any plan. Fewer than one in 10 (9 per cent) felt very involved.

Thirty-eight per cent of people in our survey said they were discharged too early and 12 per cent said they were kept in hospital too long.

Sharing a written care plan

NICE has set quality standards including the following statement about communication on discharge: "People discharged from an inpatient mental health setting have their care plan sent

8. Recommendation 1.3.7 and section 1.5 in National Institute for Health and Care Excellence (2016) (NG53)

9. Recommendation 1.5.1 in NICE (2016) NG53

10. There is further information about all the services mentioned in this briefing online. Follow the links in the text or go to mind.org.uk/news-campaigns/campaigns/crisis-care/crisis-care-good-practice/

within 24 hours to everyone identified in the plan as involved in their ongoing care".[11]

A written plan, co-owned by the person concerned and those involved in providing care, should make the transition from hospital safer, smoother and more reassuring.

Yet two-thirds of people in our survey said they were not given a written care plan (66 per cent) and just under a quarter (23 per cent) said they had one. The rest didn't know or couldn't remember.

Planning for different aspects of life

NICE guidance specifies the range of issues to be included in a care plan and pre-discharge assessment.[12]

People will need care planning around their mental health problems but may need support in any aspect of life – from accommodation, work or finances, to connecting with other people.

Partnership working: Oxfordshire Mental Health Partnership

Oxfordshire Mental Health Partnership brings together six local mental health organisations from the NHS and the charity sector including Oxford Health NHS Foundation Trust and Oxfordshire Mind. It has made a real difference in the past year by working together across partners to facilitate transition, remove blocks to transfer of care, and make sure the next steps are in place.

One element of the Trust's work is a small inpatient social work team who bring a social perspective to wards and support people to leave hospital in a more timely way.

Oxfordshire Mind's role in the partnership has allowed them to develop closer links with social workers on wards and their Benefits for Better Mental Health service provides benefits support to patients as part of their pre-discharge programme.

Our survey found that that the areas of life least likely to be considered in care planning were work, education and training (69 per cent said these were not well considered if at all), social, cultural and spiritual needs (67 per cent), substance misuse (63 per cent), and money and benefits (62 per cent).[13] Despite mental health problems being the reason for admission, 51 per cent said the same for managing mental health and self-care; and 42 per cent for mental health treatment.

Notice of discharge

> "I wasn't given notice when I got discharged. I got told: 'right we're discharging you now.' And that was final – I packed my bags, the nurses escorted me off the ward, and I was left on my own. I felt so upset and so detached from the world I didn't know what was happening."

NICE guidance says to give at least 48 hours' notice of discharge.[14]

Having notice of discharge enables people to prepare practically and emotionally for leaving hospital, and for support to be put in place.

However, one in three people in our survey had less than 48 hours' notice of being discharged – even those who had been in hospital for more than a month – and one in five was given no notice at all.

Social inclusion and support: Buckinghamshire Mind and Oxford Health NHS Foundation Trust

Buckinghamshire Mind, in partnership with Oxford Health NHS Foundation Trust, have developed two Information and Option Worker support roles and one Recovery Worker role. These workers provide a vital bridge into the community for service users who are close to discharge or have not met the criteria needed to receive treatment within the NHS.

11. Quality statement 3 in NICE (2017) QS159

12. Recommendations 1.5.20 and 1.5.21 in NICE (2016) NG53

13. Percentages are of the people for whom the question was applicable.

14. Recommendation 1.7.5 in National Institute for Health and Care Excellence (2011) Service user experience in adult mental health CG136 www.nice.org.uk/Guidance/CG136

Delivering care

"If I had had the support promised on discharge I wouldn't have ended up having another crisis three months later during which I self-harmed and attempted suicide. Support is better at the moment."

The test of planning is people's experience of leaving hospital and their subsequent care, although good plans may still not deliver in the face of shortfalls in resources and other barriers.

There are different approaches to getting people the support they need, and ensuring this is person-centred, recovery-focused and equally accessible.

Navigating community options: Carlisle Eden Mind and partners

Carlisle Eden Mind works in partnership with a legal centre, a housing adviser and Citizens Advice to provide people with a connected route to support and advice in the community, including people leaving acute inpatient services. Their evening crisis centre is also an important resource for people accessing support in the community and those who have left hospital and need a safe place to go to.

Meeting diverse needs: East London NHS Foundation Trust working in Bedfordshire

East London NHS Foundation Trust's Diverse Cultures team has an ethnically diverse staff, providing a flexible, culturally competent service to meet the needs of black and ethnic minorities (BME), including those of Eastern European origin, who have a diagnosed mental health condition. Their offer includes patients' rehabilitation and care pathways, including reintegration into the community following discharge from hospital care.

Therapeutic continuity and social inclusion: Oxleas NHS Foundation Trust

The Bromley Day Treatment Service (DTS) offers an alternative to inpatient admission and provides therapeutic continuity for people leaving hospital. Up to 8 weeks of therapeutic interventions enable people to develop coping strategies, make positive lifestyle choices and gain a greater understanding of their mental health and wellbeing.

I was in hospital for 15 months and in the following four months had two appointments. I've since had a severe relapse and may have to be readmitted.

In our survey just 21 per cent of people said they had all the support they needed, 53 per cent had some support but not enough and 24 per cent had none at all.

In the areas of life that were least likely to be considered in discharge and care planning a half or more of people said their needs were not met at all.[15]

Despite NICE guidance on accommodation[16] only one in five people had their accommodation needs fully met, while almost half (47 per cent) did not have housing needs met at all.[17] [18]
A hospital admission should never be the cause of homelessness, while having somewhere safe to stay is the most basic need on discharge from hospital. However, one local Mind that provides a housing service told us of three people who had been dropped off at their local council's homeless team office after discharge; ie, discharged to 'no fixed abode'.

Specialist housing social work: Bradford Council and partners

A specialist housing social worker based in the NHS mental health acute care team supports inpatients and others to access housing quickly and easily and will assess housing issues soon after admission. This professional has been key in getting people accommodation and reducing delayed transfers of care.

2 out of 3 people received no written care plan

15. That is people for whom these needs were applicable.

16. Recommendations 1.5.7 and 1.5.8 in NICE (2016) NG53

17. Percentages are of the people for whom the question was applicable.

18. We are doing more in-depth work on housing and mental health to be launched in 2018.

Peer support

NICE guidance says to consider providing group-led peer-delivered self-management training and, for people with more than one previous admission, peer support.[19]

Peer support: Leeds Mind

Leeds Mind has a peer support programme that delivers a range of courses and workshops. They also have peer support workers based with a trust rehab and recovery unit to support people's transition between inpatient services and the community or supported living, which can last up to six months after leaving the unit.

Only 14 per cent of people in our survey had their needs for support (peer-led or otherwise) with managing mental health and self-care fully met and more than one in four (27 per cent) did not have these needs met at all.

Conclusion

In far too many cases NICE guidelines are not being followed; too often people are left to cope alone. This puts recovery at risk and may lead to further crises, readmissions and even suicide, which take an enormous and preventable toll on people and their families. It is also a costly and short-sighted approach to healthcare.

The service examples show what can be done, often in partnership between statutory and voluntary services. Good partnership working and commissioning that values the voluntary sector, and our role in service design, is an important way to improve outcomes for people who have come through a mental health crisis. The relationships built in crisis care concordats provide an excellent route to improving care at the end of crisis care.

We're calling on every crisis care concordat partnership, CCG and mental health trust to review discharge practice and provision and ensure that everyone leaving hospital gets the right care and support.

19. Recommendations 1.5.13 and 1.5.14 in NICE (2016) NG53

Resources

Planning for recovery, Mind, 2017. Booklet for anyone leaving hospital after a mental health crisis to help you take part in your own discharge and care planning. Request bulk copies from mind.org.uk/leaving_hospital.

Transitions between inpatient mental health settings and community or care home settings (NG53), NICE, 2016. Guidance on admission and discharge including more areas than are covered in this briefing.

Transitions between inpatient mental health settings and community or care home settings (QS159), NICE, 2017. Four quality statements based on the NG53 guideline.

Acute Mental Health Care Pathway for Adults and Older Adults, National Collaborating Centre for Mental Health, due out late 2017 on rcpsych.ac.uk. NHS England version will be published on england.nhs.uk.

This briefing is focused on evidence and practice in England. NICE guidance also applies in Wales, where additional rights and duties apply through the Mental Health (Wales) Measure:

Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010, Welsh Government, 2012, assembly.wales.uk. Guidance on the Measure's provisions on care coordination and care and treatment planning and on the assessment of former users of secondary mental health services.

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