Achieving Excellence in Person-Centred Discharge from Inpatient Mental Health Settings

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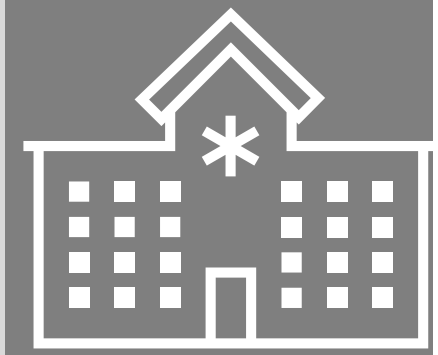
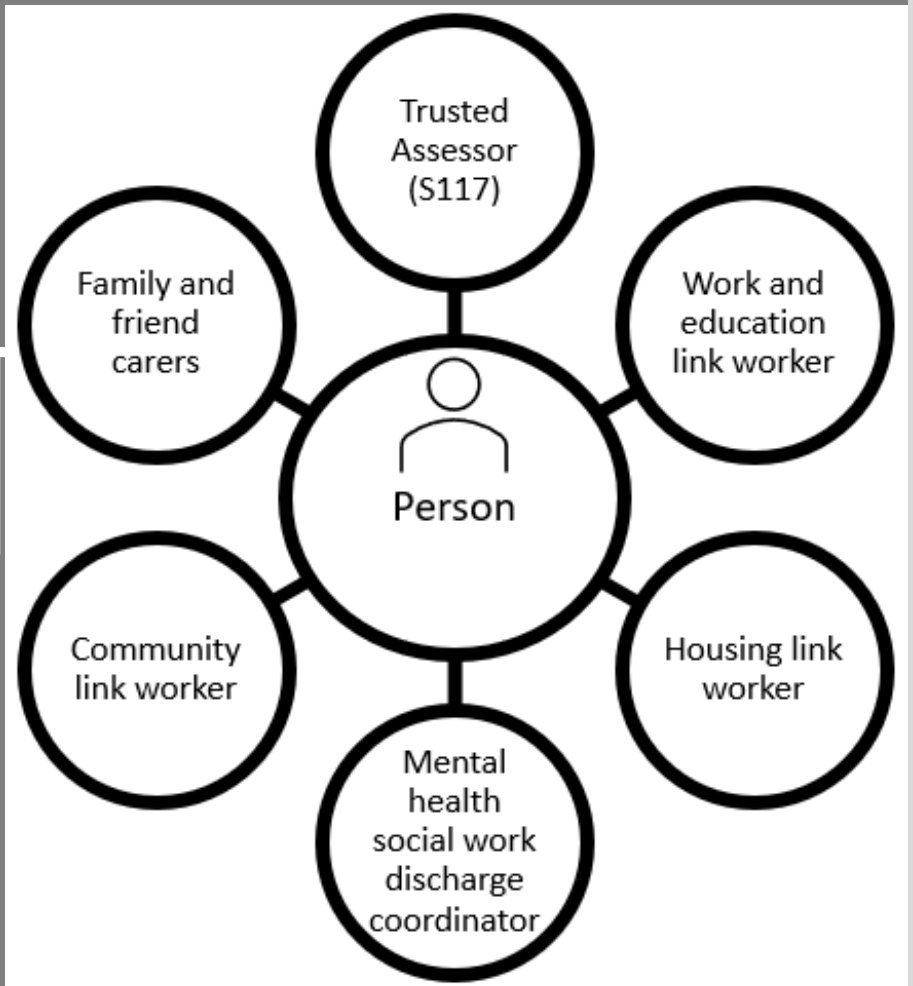
Framework for Achieving Excellence in Mental Health Discharge

Hospital admission is triggered by a crisis and/or deterioration in mental health and requires admission to mental health inpatient unit either as formal or informal patient.

Strengths-based recovery focused discharge planning from admission – with <u>minimum</u> weekly muti-disciplinary team meetings





Wellness and Recovery Action Plan (WRAP)

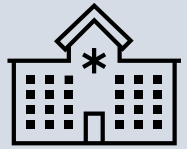
Pathway One:

Pathway one

Home with support (including supported living)

Pathway Two:

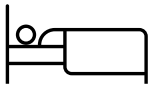
Pathway two



Specialist step down recovery / rehabilitation beds

Pathway Three:

Pathway three



Specialist residential / nursing care

Principles for Effective Discharge from all Mental Health Inpatient Services

Statutory guidance, Discharge from mental health inpatient settings, Published 26 January 2024, DHSC

Principle 1	Individuals should be regarded as partners in their own care throughout
Principle 2	Chosen carers should be involved as early as possible
Principle 3	Discharge planning should start on admission or before
Principle 4	Health and local authority social care should work together to support person centred, timely discharge
Principle 5	There should be ongoing communication between hospital teams and community teams before, during and after
Principle 6	Information should be shared effectively across relevant health and care teams
Principle 7	Local areas should build an infrastructure that supports safe and timely discharge,
Principle 8	Funding mechanisms for discharge should be agreed aligned with existing statutory duties

Core Components

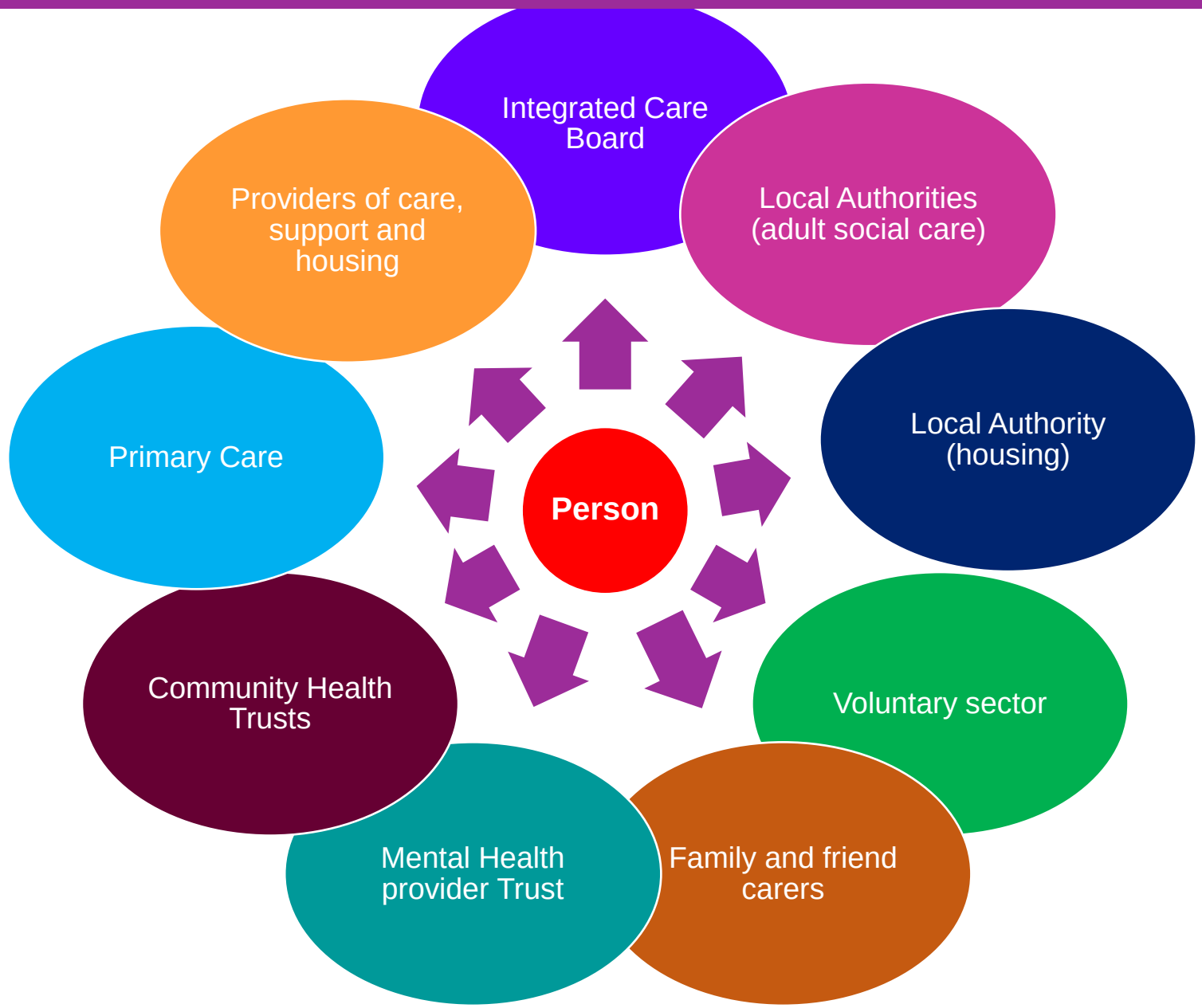
Section One: Essential system partnerships
Section Two: Language and frameworks
Section Three: The Pathways
Section Four: References and further resources

Section One

Essential System Partnerships

Essential System Partnerships

Who Are the Key System Partners?



Essential System Partnerships

Integrated Care Board

Community Health Trust

Mental Heath provider trust

Voluntary sector

Primary care

Local Authority (social care)

Local Authority (housing)

Family and friends' carers

Providers of care, support and housing

Focus on outcomes for the person not organisational boundaries

Locally agreed protocols setting out:

- roles and responsibilities and timescales for responding
- Arrangements for funding (117 and CHC)
- Strengths –based risk management

Joint commissioning arrangements that provide high quality rehabilitation, recovery and enablement support for positive mental health

Access to housing and supported living to support timely discharge

Clear focusing of existing services to support prevention, rehabilitation, recovery and enablement

Arrangements in place with transfer of care hubs to enable people with physical health needs (as well as mental health needs) to access local discharge to assess services

Essential System Partnerships – Top Activities

Integrated Care Board(s)

Ensure robust arrangement are in place for identifying continuing health care responsibilities and providing bridging arrangements to support discharge prior to determination of CHC eligibility if required.

Local Authority Adult Social Care

Identify dedicated mental health social work discharge coordinator(s) to work as part of the multi-disciplinary team undertaking statutory Care Act functions and focusing on strengths-based, recovery focused, outcomes. This includes close liaison between the Mental Health Trust and Council for services within a section 75 and robust joint working when services are delivered directly by Councils.

Mental Health Trust

Undertake Section 117 duties – ideally considering options for Trusted Assessment to enable a single joint assessment

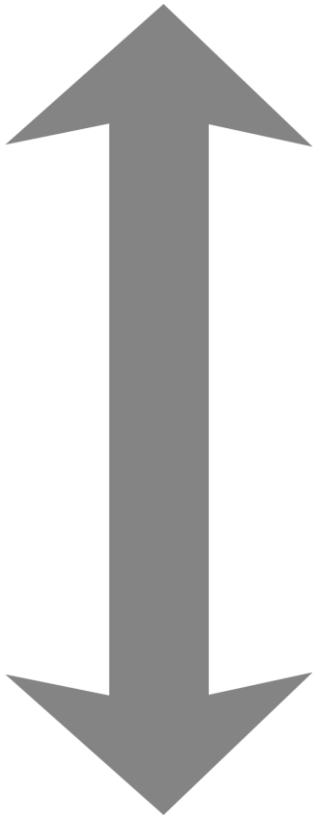
Ensure services are designed in partnership with people with lived experience/carers

Section Two

Understanding the language and frameworks

Reducing time in hospital through focused interventions

Within 72 hours of admission



- Complete a holistic assessment
- Agree a purpose of admission and an estimated discharge date (EDD)
- Commence mental health and physical health interventions
- Strengths-based care planning in place
- Commence discharge planning

Red to Green

Ward round / daily multi-disciplinary meetings are focused on plans, making sure people have the right interventions (e.g. therapy, medication reviews etc) to move their care on every day (green days) rather than wasted days in hospital waiting for interventions (red days)

Taken from: NHS England » Acute inpatient mental health care for adults and older adults

Section 117 – what is it and why is it important for discharge?

Section 117 (of the mental Health Act 1983) places legal obligation for the NHS and local authorities to provide after care for people who have been detained under certain qualifying sections of the Mental Health Act.

It exists **to guarantee support and services** to people after being discharged and is used as a mechanism to try to avoid or minimise the person being readmitted to hospital.

After care is defined as both:

"(a) meeting a need arising from or related to the person's mental disorder;
and
(b) reducing the risk of a deterioration of the person's mental condition (and, accordingly, reducing the risk of the person requiring admission to a hospital again for treatment for mental disorder)."
(MHA section 117 / Care Act section 75 (5)

Section 117 applies to	Section 117 does not apply to:
• Section 3 (admission for treatment) • Section 37 ('hospital order') – includes s.37/41 • Section 45A (where a criminal court imposes a prison sentence but directs, they start their sentence in a psychiatric hospital for treatment) • Sections 47 and 48 (the transfer of prisoners to hospital) • Includes those on leave (s17) who have left the hospital to live somewhere else (but not for purposes of escorted day trips into the community) • Those subject to Community Treatment Orders (CTOs)	• People detained in hospital for assessment under Section 2 • People detained in an emergency under Section 4 • People detained while already in hospital under Section 5(2) • People who were not detained under any formal MH Act section (informal

Discharge to Assess or Assessment in hospital?

Discharge to Assess (D2A)

Person is discharged from hospital in advance of any statutory assessment of long-term health and or social care need (Care Act Assessment or CHC assessment). If applicable section 117 assessments must be completed and Wellness, Recovery, Action Plans (WRAP) should specify D2A outcomes. Follow up to be carried out with the person by the CMHT or CRHTT at the earliest opportunity and within a maximum of 72 hours of discharge, to ensure the right discharge support is in place.**Discharge to assess services are provided free at the point of delivery and can be delivered in a persons home or in a bed-based setting. They are designed to be short term and should be focused on rehabilitation, reablement / enablement and recovery**

Assessment in Hospital

Section 117 assessments **must** be completed prior to discharge. Depending on local arrangements Care Act Assessments or Continuing Health Care assessments can be done through a discharge to assess arrangement if appropriate. The timescales and arrangements for these assessments must be set out in the WRAP Plan

The Recovery Model

The recovery model is a holistic, person-centred approach to mental health care. It is based on two simple premises:

- It is possible to recover from a mental health condition.
- The most effective recovery is patient-directed.

Recovery Model Focus:

- Building resilience to cope with the challenges of mental illness
- Validating personal experience
- Improving quality of life
- Cultivating strategies for when challenges arise and always aiming to do ‘with’ people rather than ‘to’ or ‘for’ people
- Focusing on what people can do rather than what they cannot do
- Supporting people to develop skills to help themselves stay well and ·working with the whole person and not just their diagnosis

The Wellness and Recovery Action Plan (WRAP)

Wellness Toolkit	Daily Maintenance plan	Relapse prevention	Crisis / Post Crisis management plan	Support
A written description by the person about what they are like when they are feeling well and what others notice about them Can be just a few words or written from some one else perspective, e.g. my friends say I am kind and considerate Clear message person has been well before and the suggestion that they'll be well again/maintain their current level of wellness. Provides a picture of the s person at their best.	Person supported to: • make a list of things they need to do each day to keep themselves feeling well. E.g.,. exercise each day, eat well, get to bed early, meditate • identify things they might need to do each week / every so often to keep themselves feeling well. E.g., get a massage, go to the movies, have some quiet time, go for a walk • make a list of people who are helpful to them and how often they should contact them	When working with people to identify external events/circumstances and the impact and frequency e.g., workloads, family friction, being overtired, anniversaries, Person encouraged to make an action plan list of ways to respond to help them feel better as quickly as possible and prevent an even more difficult time.	Identify early signs of relapse and create a plan e.g. • Unable to sleep • Having suicidal thoughts • Wanting to use more alcohol and/or drugs • Spending lots of money or more than usual Identify the intervention to prevent relapse increase support to manage the feelings	how the persons: • family and friends have been involved in their treatment / supported them in the past • would like family and friends to support them in the future what kind of information family and friends may need to support the person who is the persons main support person along with their contact details and who can be contacted if they are not available

Discharge Planning from Admission - Definition of Key Roles

Trusted Assessor (section 117)	**Professional trusted to undertake section 117 assessment on behalf of NHS and local authority**
Work and education link worker	**Usually a professional voluntary sector organisation(s) who can support with engagement in new or existing work or education activities**
Mental health housing link worker	**Professional who can support with identifying and solving housing and tenancy issues**
Mental Health social work discharge coordinator	**Professional to undertake an assessment in response to the appearance of need of need as defined by the Care Act for the person (section 9) or the Carer (section 10).**
Mental health community link worker	**What local community assets are in place that can support on discharge, services, social activities, therapeutic and well-being activities, technology / digital support. Any employment support needed?**
Family and friend carers	**Individuals who provide unpaid care and support for the person**

Discharge Planning from Admission - Key Areas of Focus

Plan for discharge on admission with holistic strengths-based recovery plan within 72 hours, clear plan on the in-patient treatment plan (using Red to Green) and the likely medium to longer term community support requirements.

Regular (minimum of weekly) multi-disciplinary (MDT) meetings involving the person or advocate, family and or friend carers and other relevant professionals to develop and deliver a with strengths-based discharge plan

Person (or advocate)	**What's important to me? what's important for me? and how can this support discharge planning? (the make up of the MDT can be determined by the answers to these three questions)**
Mental Health MDT	**Who is part of the MDT that will support after discharge? What is the skill mix. Are the right level of therapeutic supports available?**
Primary and secondary health care	**Are the GP and primary care linked in at the right levels, for example medication, pharmacy, therapy, diabetes, etc.**

Section Three

The Pathways

The Pathways and Discharge: Pathway One

Pathway One:

- **The aim should be for a person to return home or to their usual place of residence on discharge – with appropriate support in place promptly**
- **It will apply to every person leaving hospital to go home with a section 117 plan or with the intention of an assessment by the NHS or social care in the community (D2A).**
- **If a person needs access to physical health as well as mental health then they should be able to access locally commissioned rehabilitation, Reablement/enablement and recovery services at home**

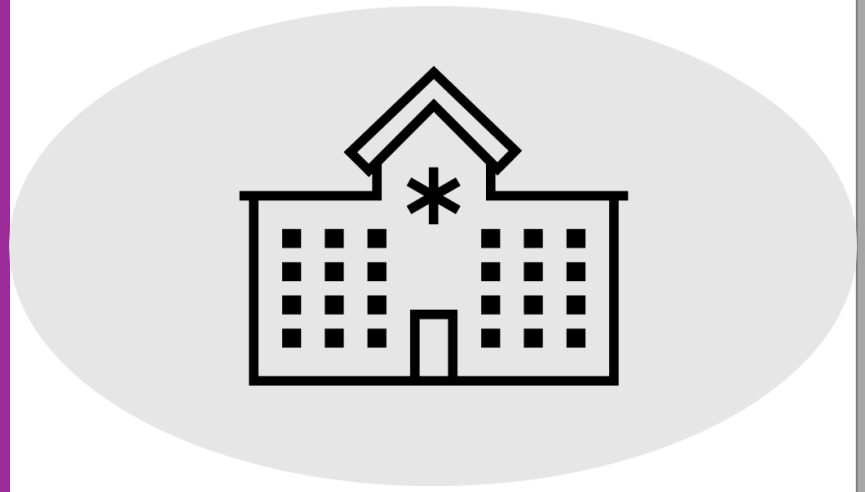
Pathway One Incudes:

Community mental health recovery support, tenancy and housing support, supported living, packages of care and support including direct payments, enhanced GP or primary care support, rehabilitation or enablement support for mental health including work and education. It also includes short term support provided within a supported living / housing scheme that is not a registered residential home.

For physical health needs access to acute rehabilitation, reablement and recovery (3R) resources

The Pathways and Discharge: Pathway Two

Pathway two:



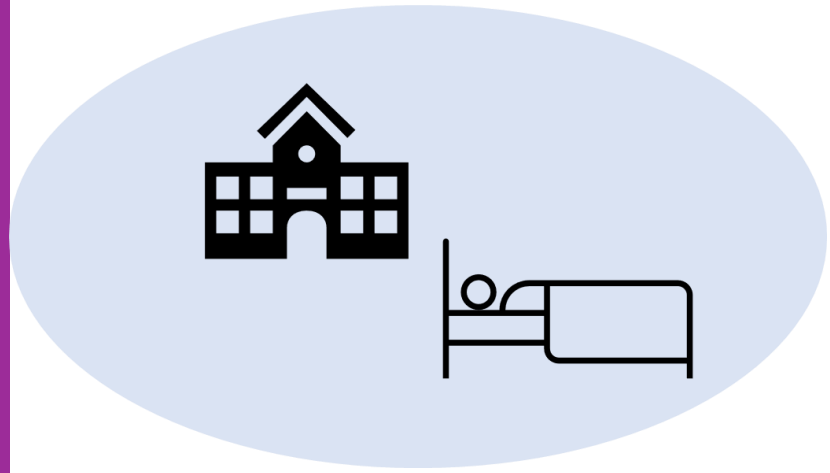
- **If a person needs a continuation of intensive support that is over and above what can be provided in the community then a step-down to rehabilitation / recovery bed may be appropriate with a view to supporting the person to return home after a further period on intervention(s)**
- **Pathway two beds can be hospital beds or registered nursing or care home facilities. The key is that they are a time limited intervention with a view to the person returning home. If longer term care and support in a bedded setting is likely to be needed this will be another move for the person**
- **If a person needs access to physical health as well as mental health then they should be able to access locally commissioned bed-based rehabilitation, reablement and recovery services**

Pathway two incudes:

Specialist step down recovery / rehabilitation beds for mental health recovery, for physical health needs access to acute rehabilitation, reablement and recovery (3R) bed-based resources

The Pathways and Discharge: Pathway Three

Pathway Three



- **If a person is unlikely to be able to be supported at home even with support, then consideration may need to be given to a pathway three bed.**
- **Pathway three beds are generally only for people who are unlikely to recover sufficiently to enable them to return home (or who are already in nursing or residential care prior to admission).**
- **Just because a person has been admitted to a pathway three bed it does not mean they cannot return home, but they should not be expected to move again if long term care is required**
- **If a person does needs specialist residential or nursing care efforts should be made to source this provision locally wherever possible**

Pathway Three Incudes:

A range of residential and or nursing support particularly; dementia support, extreme self neglect linked to mental health, Korsakoff, specialist Learning Disability or Autism services

Discharge Arrangements

Prior to Discharge

People, families and relevant professionals (e.g., housing, community teams, adult social care etc.) should be given 48 hours notice of a decision to discharge.

A risk assessment must be completed in collaboration with the patient

A follow up meeting arranged (72 hours post-discharge)

Information for people / families on crisis support

Discharge plans shared with, patient, carer and relevant professionals including GP

Taken from: NHS England » Acute inpatient mental health care for adults and older adults

Section Four

References and Further Resources

References and Further Resources

- Acute in-patient care for adults and older adults (2023) [available at] NHS England » Acute inpatient mental health care for adults and older adults
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- NHS Long Term Plan [available at] NHS Long Term Plan » Mental health NHS Mental Health Implementation Plan 2019/20 – 2023/24 (longtermplan.nhs.uk)
- No Wrong Door (2022) [available at] No wrong door | NHS Confederation
- Strengths Based Practice Framework (2019) [available at] https://www.gov.uk/government/publications/strengths-based-social-work-practice-framework-and-handbook
- The Care Act (2014) [available at] Care Act 2014 (legislation.gov.uk)
- The Mental Health (1983) [available at] Mental Health Act 1983 (legislation.gov.uk)