



Tailored resources

Tailored service improvement support

Published: 20 April 2017

nice.org.uk

Contents

Introduction	3
Why should you put this guideline into practice?.....	3
Key messages.....	5
1. Delivering services that are person-centred and focused on recovery.....	6
The guideline and legislation	6
Example.....	6
Local learning	6
2. Ensuring effective communication between teams and with people using services, families and carers	8
The guideline and legislation	8
Example.....	8
Local learning.....	8
3. Co-producing comprehensive care plans that meet people's changing needs	10
The guideline and legislation	10
Example.....	10
Local learning.....	10
Resources and useful links.....	12
Social work.....	12
Recovery	12
Person-centred care	12
Co-production	12
Acknowledgements.....	14
About this tool	15

Introduction

This resource is for people working in adult social care, mental health services (both community and inpatient settings) and third sector organisations to support good practice. It draws on discussions at a workshop held in November 2016 which focused on implementing NICE's guideline on [transition between inpatient mental health settings and community or care home settings](#) for adults moving to and discharged from inpatient mental health settings.

With the support of the NICE Collaborating Centre for Social Care (NCCSC), the workshop was held in the London Borough of Newham. In Newham, social workers who previously worked in the community mental health team are now managed by the local authority. The workshop was attended by people with roles in mental health and social care, including senior managers, psychiatrists, social workers, hospital ward staff and bed managers, housing workers, and community care workers. People who used mental health services also attended to provide accounts of their own experiences.

The resource provides:

- information to support implementation of the recommendations in NICE's guideline on transition between inpatient mental health settings and community or care home settings
- information and learning points from the workshop
- links to relevant resources.

There is also a tailored resource that focuses on services for children and young people:

- [Working with young people to plan person-centred care and support for admission to and discharge from inpatient mental health settings](#).

Why should you put this guideline into practice?

NICE guidelines are made up of evidence-based recommendations for health and care in England. This guideline addresses the often difficult period before, during and after admission to, and discharge from, a mental health hospital. It is about improving the quality of care for everyone who uses mental health inpatient facilities, including children, young people and adults, and people who have other health issues and care needs. Through a set of recommendations and implementation challenges it aims to help children, young people and adults who use mental health services, and their families and carers, to have a better experience of transition by improving the way it is planned and carried out.

In addition, the Care Quality Commission (CQC) uses NICE guidelines as evidence to inform the inspection process. The CQC key lines of enquiry and prompts for inspectors expand on areas the guideline covers and include: involvement of people and their families in care planning, pathways of care, access to advocacy and discharge planning. The CQC key lines of enquiry, set out in [appendices to the provider handbook for specialist mental health services](#), provide a useful point of reference for local service planning and development.

Key messages

The workshop used the guideline as a starting point to review current practice and to identify challenges and priority areas for improvement. Detailed discussions at the workshop identified 3 key areas crucial in providing effective support:

1. Delivering services that are person-centred and focused on recovery – leading to care and support that is tailored to the unique needs of the person and supports their recovery.
2. Ensuring effective communication between teams and with people using services, families and carers – leading to closer working between multi-disciplinary teams and better coordinated care for the person.
3. Co-producing comprehensive care plans that meet people's changing needs – leading to improved continuity of care for people as they move between services.

1. Delivering services that are person-centred and focused on recovery

The guideline and legislation

Sections 24 and 25 of the [Care Act 2014](#) outline that people should be in control of their support and should be actively involved in influencing their care and support. The act states that "the guiding principle in the development of the plan is that this process should be person-centred".

One of the overarching principles of the guideline is that care and support should be person-centred and focused on recovery (recommendation 1.1.1). This can be achieved through working with people as active participants in their own care and transition planning (recommendation 1.2.2).

The NICE guideline and the act together provide a useful practice and legislative framework to support development of person-centred, recovery-focused services.

Example

The 'I' statements were developed by people who use mental health services and practitioners to ensure a focus on the needs of the person in planning and support. The statements are:

- Who I am.
- What's important to me.
- How I wish to be supported.
- How people behave with me.

Jointly published by Think Local Act Personal and National Voices, [No assumptions: a narrative for personalised, coordinated care and support in mental health](#) is part of the [Making it Real](#) programme and provides more information about the 'I' statements and has a number of examples of putting them into practice.

Local learning

Discussions at the workshop covered several key themes relating to delivering person-centred, recovery-focused services: systems; involving people; joint working; care and support planning; services; and culture.

Systems

Successful transition from an inpatient mental health setting to a community or care home setting is dependent on services that are person-centred and have a focus on recovery.

A core component of person-centred, recovery-focused services is effective joint working. Joint working can be supported by commissioning 'recovery-focused' services, including housing support services. Practitioners can also use discussions around section 117 aftercare rights as an opportunity to work together across health and social care. (Section 117 of the Mental Health Act 1983 entitles people to free aftercare following a stay in hospital under certain sections of the act.)

Starting care and support planning on admission enables good transition on discharge from hospital (recommendation 1.3.7 and 1.5). Using the "I" statements helps to ensure that planning is focused on the person. The [Care Programme Approach](#) (CPA) informs care planning beyond admission.

Person-centred support

Working with family members from an early stage is critical to supporting person-centred practice. If the person using services does not want their family directly involved, practitioners may need support to communicate with them in an appropriate way (recommendation 1.4). For example, practitioners can still listen to family members without compromising confidentiality.

Other factors that contribute to a positive experience for the person are:

- Including risk assessment and management in planning.
- Ensuring that there are enough skilled staff to work with people in crisis on wards.
- Making sure that there is no delay once a person is well enough to move on from hospital.
- Ensuring that commissioning to support recovery includes the role of housing in the pathway and working with housing landlords and management to prevent people from losing tenancies.
- Promoting mental health advocacy services.
- Supporting access to peer support.
- Ensuring that therapeutic relationships are maintained.
- Focusing post-discharge follow-up on recovery goals and the needs of the person.

2. Ensuring effective communication between teams and with people using services, families and carers

The guideline and legislation

The [Care Act 2014](#) requires integration, cooperation and partnership working between local authorities and key partners (sections 3, 6, 7, 22, 23, 74 and schedule 3). Although not explicitly referenced in the act, effective communication is implicit as a keystone to successful partnership working.

Ongoing communication between teams is key to effective transition between inpatient mental health settings and community or care home settings, as is good communication with people using services, their families and carers (recommendations 1.4.1 and 1.4.2). Effective systems to enable practitioners to communicate easily and clearly are outlined in the guidance.

Example

Communication with people experiencing a mental health crisis can be very difficult. Practitioners may feel that they are communicating clearly, but the person may be too distressed to take in and remember information (recommendation 1.3.5).

For example, in Newham, people were sometimes unaware that they had been sectioned under the [Mental Health Act 1983](#), even though this had been clearly explained when they were admitted to hospital. Recognising that verbal information at admission to inpatient mental health settings was not effective for everyone, the local service developed leaflets that people could read when they felt ready to absorb information.

Local learning

Systems

People should only have to tell their story once rather than repeating the same information to practitioners from different disciplines who are not communicating with each other (recommendation 1.2.8). However, communication between practitioners from different disciplines can be challenging at times, especially when they are using different IT systems. Allowing 'read-only' access to records held by partner organisations can be an effective way of improving communication.

Providing opportunities for practitioners across health and social care to come together enhances communication. Examples include shared training events and invitations to team meetings. Communities of practice also provide opportunities to improve communication and to share good practice.

A lead practitioner should coordinate the planning and management of a transition and should ensure that all professionals involved in the transition know each other's roles and responsibilities and are clear about their input, if any, to specific treatment and to planning the transition.

Bed management meetings should be held as frequently as is needed to avoid delayed transfer and should involve community and inpatient practitioners from the multidisciplinary team.

Person-centred support

Decisions about a person should not be made without their involvement ('No decisions about me, without me') or without the involvement of key members of the multidisciplinary team. Avoiding jargon when planning with a person will help to ensure that they have a good understanding of their plan.

Carers need support that is bespoke rather than generic because demands on carers will differ considerably according to the needs of the person they support. Carers will also benefit if they have access to a comprehensive directory of support.

3. Co-producing comprehensive care plans that meet people's changing needs

The guideline and legislation

Section 10.14 of the [Care Act 2014](#) states that people should be in control of their care: "The person [should] be actively involved and have the opportunity to lead or strongly influence the planning and subsequent content of the plan. Joint planning does not mean a 50:50 split; the person can take a bigger share of the planning where this is appropriate and the person wishes to do so." This detailed guidance should provide support in implementing this NICE guideline.

Working with people to co-produce care plans is one of the overarching principles of the guideline (recommendation 1.1.2). Co-production involves engaging and communicating with people and their families to ensure that support is person-centred. The guideline also describes early, focused planning as being a key factor in supporting effective co-production of plans (recommendation 1.37).

Example

Low-cost and simple ideas can make a big difference to ensuring care plans meet people's changing needs.

For example, some people may find it difficult to find ways to occupy themselves after being discharged from inpatient mental health settings, so discharge planning could include information about activities. One of the wards at a hospital in Newham has produced a pack that lists local activities, including sports clubs and drop-in classes. The pack is photocopied and given to people when they are close to being discharged. It is also shared with other settings.

Local learning

Systems

Practice, involving people and systems, is important for successfully co-producing care plans that are comprehensive and meet people's changing needs.

At a systems level, a single assessment and care plan that is shared with all members of the multidisciplinary team helps to support co-production. Where health and social care records are held separately, it is important to establish a common approach to assessment.

Feedback from people using services helps future planning, so it is important that good systems are in place for collecting feedback. Feedback should be shared with service providers and with commissioners so that they are aware of providers' performance.

Person-centred support

Focusing on the strengths of the person when assessing their care needs (strengths-based practice) underpins effective co-production. This approach may be new to some practitioners, but they can be supported through supervision to change their practice so that they focus on the person's abilities and what keeps them well and independent.

A default position of recognising the person as the 'expert by experience' also supports co-production. Real, thoughtful co-production requires learning and development for practitioners, so that they feel confident in co-production.

Planning in advance for people who may need crisis support can help to prevent referrals happening at crisis point.

Resources and useful links

Social work

- Department of Health (2016) [Social work: improving adult mental health](#). A report looking at the role of social workers in supporting people with mental health problems.

Recovery

- Centre for Mental Health [What is recovery?](#) An explanation of the concept of recovery.
- Implementing Recovery through Organisational Change (ImROC) [Resources supporting the 10 key challenges](#). Ideas on how to overcome 10 challenges to supporting recovery.
- Mental Health Foundation [Recovery](#). Information about supporting recovery.
- Nursing Times (2014) [Recovery focused practice in mental health](#). Information for nurses about supporting recovery.

Person-centred care

- Making it Real [No assumptions: a narrative for personalised, coordinated care and support in mental health](#). Using the 'I' statements to support person-centred care.
- NHS Choices [Care programme approach](#).
- NICE (2011) [Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services](#). NICE guidance on person-centred care.
- NICE (2011) [Service user experience in adult mental health](#). NICE quality standard on person-centred care.
- Think Local, Act Personal [Person-centred, coordinated care](#). Information about ensuring that services are person-centred.

Co-production

- Mind (2013) [Co-production in mental health – why everybody wins](#). Advice on how to put service users at the heart of planning and delivering mental health services.
- New Economics Foundation (2013) [Co-production in mental health: a literature review](#). A review of how co-production is being used in mental health.

- National Survivor User Network (2015) [4Pi national involvement standards](#). Information about the work of the National Involvement Partnership.
- Social Care Institute for Excellence [Co-production in social care: what it is and how to do it](#). A practice example of co-production in a mental health service.
- Time to Change (2016) [300 voices toolkit](#). A toolkit to improve the outcomes of young African and Caribbean men in inpatient mental health services.

Acknowledgements

We would like to thank all participants and their organisations for their contributions to the workshop, particularly Carys Essen, Senior Commissioner (London Borough of Newham) who helped us plan and hosted the event. This resource has been written by Lisa Smith (Assistant Director, Research in Practice for Adults), with support and guidance from the NICE Collaborating Centre for Social Care, a partnership led by the Social Care Institute for Excellence.

About this tool

This tool is based on NICE guidelines and quality standards published up to August 2016 about transition between inpatient mental health settings and community or care home settings.

You can find out more about NICE [guidelines](#) and [quality standards](#) on our website.

ISBN: 978-1-4731-2485-1