

# A POSITIVE OUTLOOK

A good practice toolkit to  
improve discharge from  
inpatient mental health care

April 2007

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# Foreword

We welcome this important addition to our efforts of improving delivery of inpatient mental health services. 'A Positive Outlook' good practice toolkit contains clear messages about the needs and benefits of focusing on reducing present levels of delayed discharges from hospital and provides clear evidence from the range of positive and innovative practice developing in local services that such a reduction is achievable.

Our aim is to ensure that best practice in facilitating safe and effective discharge becomes common practice. If we succeed in this, it will be a major contribution to reducing pressure on inpatient wards, by enabling more therapeutic and effective treatment and facilitating the recovery and wellbeing of service users and carers.

The wealth of positive practice examples featured in this toolkit are a testimony to the dedication and service development expertise that characterise so many local services and those who use and work in them. Our thanks and congratulations go to all involved.

This toolkit is not just for acute mental health staff and management but is equally relevant to the wider mental health and social care services commissioner and provider agencies. All have a part to play. A key theme running through so many of the positive practice examples is that developing clearly defined joint working arrangements within and across local services is central to overcoming current barriers and using resources to their full potential across the care pathway. In successfully tackling delayed discharge issues, the sum is very much greater than the parts!

'A Positive Outlook' is a very accessible good discharge toolkit that can assist and encourage local services to analyse their delayed discharge issues and develop their own solutions informed by what works elsewhere. We commend it to you.



**Professor Louis Appleby**  
*National Clinical Director for Mental Health*



**Professor Ian Philp**  
*National Clinical Director for Older People*

# Executive summary

Bed occupancy rates of 100% or more, pressures to find a bed, overcrowded wards and the associated negative consequences for effective therapeutic engagement, service quality, safety and service user recovery are all too familiar for many of our inpatient mental health services. Despite these pressures and associated demands to increase inpatient capacity, we have 9% of our mental health admission beds unavailable due to delayed discharges.

Delayed discharges disrupt the therapeutic potential of the ward, create dependence in service users and waste scarce resources. The evidence also shows that it is in areas of greatest pressure on beds that there are the greatest number of delays. There is even more scope for improvement: the 9% of beds that are unavailable due to delayed discharges do not include those inpatients who are ready for 'early discharge' from hospital to community acute treatment services.

There are many reasons why delayed discharges occur which require locally sensitive analysis and action planning. However a high level of delayed discharges often indicates a lack of clarity regarding the delivery of a locally integrated whole system, inadequate monitoring systems, poor discharge practice and a lack of service wide management action.

Far from being an intractable problem, this toolkit describes a wealth of practical examples which demonstrate that effective discharge practice reduces delayed discharges and promotes individual recovery. We need to spread the word.

## What works: A summary of key points

### Whole Systems and Care Planning

- A commitment to whole system working is required to develop a shared understanding of the issues. This works best when all local key stakeholders involved agree a collaborative action plan to reduce delayed discharges.
- The hospital (acute inpatient services) and community components (Crisis Resolution Home Treatment) of the acute care pathway are best delivered when they are effectively integrated, defined and agreed.
- For adult acute mental health services, Acute Care Forums (ACFs), working closely with their local NSF Local Implementation Teams (LITs), are the appropriate vehicle to discuss, devise and deliver local whole system integrated care proposals.
- Streamlining processes and changing practice are as important as investment in capacity.
- Workforce skills are needed regarding service and process redesign, collaborative principles, lean thinking and practice development.

### Admissions Management

- Agreed inter-agency integrated care protocols, which incorporate the purpose of admission and the role of the acute ward will improve service co-ordination.
- The CRHT service should gatekeep all acute admissions and provide access to a 24/7 service. This service should also have a clear role in facilitating early discharges.
- Effective single system 24 hour admissions management and joint care arrangements need strengthening, particularly between CRHT and acute inpatient wards.

- The reasons for admission should be clearly documented and an expected date of discharge should be set at admission. Addressing these issues should be proactively managed against the care plan.
- Service user and carer input is central to all aspects of discharge planning arrangements. There is a need to maximise the potential of direct payments, advance directives and advocacy.
- Timely, safe and appropriate discharge is the result of good care planning from the decision to admit to providing post discharge support
- Single management and staff team arrangements will help deliver integrated care solutions.
- The development of less restrictive alternatives to inpatient admission such as crisis or respite houses and acute focused day services will help to reduce unnecessary inappropriate admissions and promote early discharge.

### **Risk assessment and Discharge Planning**

- It is important that the same evidence based continuous risk assessment processes are consistently applied across the care pathway.
- It is important to ensure that the practical and social reasons influencing the admission have been addressed.
- Specific attention should be given to ensuring staff competence in the care and discharge planning for service users with 'dual diagnosis' problems.
- Specific discharge co-ordinator posts can help organise and expedite discharge arrangements across the service system.
- Medicines management should be a core component of discharge planning.

- Discharge information should be sent to the GP prior to the service user's discharge from hospital.
- Service users with 'dual diagnosis' problems, the homeless and those with a history of violence or self-harm are especially vulnerable and need rapid follow-up arrangements to be put in place.

### **Focusing Ward Arrangements**

- Clear clinical leadership arrangements should be in place.
- The role of the consultants, their engagement and commitment to improving the acute care pathway, and new ways of working are crucial. Ownership and leadership from Trust boards are also needed.
- The process of ward reviews/ward rounds need to ensure the most effective use of resources to maximise therapeutic engagement time.
- The opportunities provided to review existing roles as part of New Ways of Working and the introduction of new roles should be exploited to address current weaknesses and deficits.
- An integrated approach to training and development should be taken focusing on whole team training which includes CRHT and acute inpatient staff.
- Information systems should be in place locally to inform and monitor efforts to reduce discharge delays.
- Inpatient services should have clear working arrangements with local accommodation providers and community organisations to help keep service users connected to their social networks which will promote recovery.
- A focus on recovery approaches, social inclusion and community engagement is needed throughout the acute care pathway to promote individual recovery.

# 1 Introduction



'Delayed discharge' refers to inpatients remaining in hospital care after they have been clinically assessed as fit for discharge/transfer home or to another care setting. Delayed discharges are a significant factor with negative consequences for the effectiveness and quality of care received by service users in psychiatric in-patient wards. They also contribute to significant additional direct and indirect costs of inpatient care.

## Evidence suggests that:

- overcrowded acute psychiatric wards are common. A benchmarking survey recorded a national bed occupancy level of 100% in adult psychiatric wards (SCMH 2005). The Mental Health Act Commission recorded bed occupancy of 100% or more in roughly 75% of the acute wards that they visited between Oct 2004 and July 2006 (MHAC 2006a), and
- any attempt to improve discharge practice is dependent on robust data to establish the scale of delay and to inform the basis for action. Since April 2006, weekly Department of Health Situation Reports (SITREPS) have been extended to require the reporting of delayed transfers of care in all mental health NHS Trusts. Trends based on these returns show that 9% of all patients in mental health beds experience a delayed discharge nationally. This percentage varies between Strategic Health Authorities (SHAs) ranging from 5.2% to 15.8% for delayed discharges.

## The consequences of delayed discharges and accompanying overcrowded wards may often lead to:

- stressed, bored and anxious inpatients
- increased lengths of time other service users wait for therapeutic intervention and arrangement of care packages
- overstretched and insufficient staff
- an increased risk of serious incidents, substance misuse, self-harm, violence and aggression on wards
- potential delays in admitting appropriate at risk patients or the premature discharge of others
- inappropriate transfers of service users between wards and services
- an increased risk of service user dependence on inpatient care and subsequent loss of coping skills post discharge
- the potential damage to or loss of key personal supports for service users e.g. friends, tenancies, jobs, and
- the negative impact on staff morale, retention and recruitment.

## Contributory factors influencing delayed discharge include:

- inadequate whole system working across inpatient and community mental health services
- a lack of interagency collaboration and coherence between health, social care and housing
- a shortage of local discharge facilities
- a lack of clear protocols regarding admission and discharge criteria and the role and purpose of acute inpatient care
- a lack of key staff and service inputs and therapeutic opportunities, and
- a need for relevant feedback, monitoring, review, and reporting systems.

This good practice toolkit aims to have a practical focus by linking acute mental health policy to innovative practice and illustrating them with good practice examples which can be adapted or can inform the development of improved discharge planning and locally agreed protocols. It also aims to maximise learning by providing links to other relevant existing publications which can assist in achieving reduced lengths of stay on acute inpatient wards.

The role of the workforce is critical to achieving good outcomes by promoting effective discharge practice. Inpatient units by definition provide care for those who are most acutely distressed and unwell, requiring staff with high levels of skill and commitment. Adequate staffing levels and an appropriate skill mix supported by in-reach from other whole system service staff must underpin delivering improved discharge arrangements. Staff are our key innovators. Most of the good practice examples in this toolkit have involved and been championed by inpatient staff and their community colleagues.

In *From Values To Action* (DH 2006) the Chief Nursing Officer's review of mental health nursing, states "If we are to improve the outcomes and experiences of service users it is essential to strengthen and develop mental health nursing so that it is prepared for the future". The review contains a number of specific recommendations for improving inpatient care and cites a number of good practice examples in addition to those referenced in this guide.

## This toolkit covers both working age adult and older people's mental health services, and examines the following key themes:

- whole systems and care planning
- admissions management between the community-based teams and inpatient care
- consistency in risk assessment and discharge planning, and
- focusing ward arrangements and post discharge.

## 2 Whole systems and care planning



### Policy context

*“Inpatient care is a key component of the National Service Framework (NSF) for Mental Health, yet inpatient care is insufficiently integrated with the community based components of the NSF system of care.”*

(DH 2002)

*The Mental Health Policy Implementation Guide (MHPIG) for adult acute inpatient provision (DH 2002) identified a lack of overall system co-ordination and coherence as a key factor which contributes to poor throughput, inappropriate admissions and delayed discharges and requires the development of shared values, principles and processes across the acute care service system.*

### Whole system of integrated care

All parties need to think about how the whole system works, how changes in one part affect other parts of the same system and how they work together to achieve optimum performance in practice.

The Care Services Improvement Partnership (CSIP) Integrated Care Network produced a useful guide and discussion paper “Whole Systems Working” (2006) that can help analysis of local whole system performance.

One of the case studies in Tayside cited from *Moving On? An overview of delayed discharges in Scotland* (Audit Scotland 2005) argues that taking a whole system approach to develop a shared understanding of the issues and agreeing a local action plan is required to reduce delayed discharges.

### This audit report identified some key characteristics of effective whole system working, including:

- services are responsive to the needs and views of the individual service user or carer
- all stakeholders accept their interdependency and the fact that the actions of any one of them will have implications for the whole system, and
- there is agreement between stakeholders about the vision and values of the service and about priorities, roles and responsibilities, resources, risks and monitoring arrangements.

## Some of the lessons learnt from this whole system analysis of delayed discharges were that:

- it is important to adopt a range of strategies across the care pathway to intervene to reduce delayed discharges and to sustain improvement
- there is no quick fix or one size fits all solution, and
- changing process and practice are likely to be as important as investment in capacity.

The Tayside case study found that focusing on assessment timescales and processes in hospital was more likely to sustain longer term reductions in delayed discharges than any other single strategy.

## Acute Care Forums

For adult acute mental health care the *Mental Health Policy Implementation Guide* (MHPIG) (DH 2002) recommended the establishment of an Acute Care Forum (ACF) in each provider Trust, with links across the stakeholders of the acute care system including service users and carers, to regularly review the operation and co-ordination of the service.

ACFs can provide an empowered forum within which the core service participants of the acute mental health care system can agree the priorities for improvement, engage with other relevant agencies and plan and monitor the way forward as a joint endeavour.

Most of the examples quoted in this toolkit were developed under the auspices of the local Acute Care Forum (ACF). ACFs are a valuable means of defining and sharing best practice. ACFs should work with their local NSF Local Implementation Teams (LITs) to agree the strategic direction for local services regarding acute care.

They should specifically consider the interface between local Crisis Resolution Home Treatment teams (CRHTs) and acute inpatient services, identifying service deficits, good practice and scope for improvement in reducing length of stay and delayed discharges. ACFs should be informed of pressures on inpatient services, regularly review arrangements and, supported by LIT's, should broker and monitor whole system integrated solutions.

Guidance on the *Capable Acute Care Forum* together with *A Capable ACF* audit tool is available at [www.virtualward.org.uk](http://www.virtualward.org.uk)

## Acute Care Forum

By setting up the ACF, the Trust developed a series of initiatives focused on increasing therapeutic engagement and clinical leadership. The ACF is chaired by the director of nursing and therapies.

### Some of the areas the ACF has successfully addressed include:

- developing modern matrons for each clinical area. Each holds surgeries for service users, carers and staff to discuss any issues they have. Modern matrons also run a focus group which focuses on clinical leadership
- introduction of protected time initiative. This was introduced after reviewing one to one specialising and consultant ward rounds, and
- discharge liaison for older people (they are included in the ACF).

Modern matrons now run 'whole system meetings' that draw representatives from in-patient, CRHT, community and specialist services. Here people can jointly discuss interface issues, concerns and process map these identifying needs, obstacles, resources and potential solutions. They have commonly agreed standards that operate across the in-patient/community interface.

They are now working on clarifying reasons for admission including clear identification as to why home treatment was not feasible. Specific outcomes of admission are then determined along with care plan responsibilities, by who, by when and how this is monitored. In this way inpatient, CRHT and community staff work across an outcomes based pathway that is focused on discharge from the point of decision to admit.

## Cheshire and Wirral Partnership Trust

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A number of services and ACFs have successfully used service improvement tools and methods such as the CSIP High Impact Changes, process mapping and lean thinking to analyse local care pathways and improve discharge processes so as to make sure service and practice deficits contributing to delayed discharges are identified and tackled effectively.

### A 'lean thinking' approach to the patient path

Cumbria Partnership Trust has used the concept of 'lean thinking' to achieve a more effective care pathway from admission to discharge. They looked at the current process and the value of that process to the patient, ward and organisation in order to eradicate any waste in the system. The team identified that 50% of time/financial saving could be made if the patient pathway was "slicker". In order to address this, protocols were developed for:

- the criteria for a 'purposeful admission'
- the assessment process
- evidenced based 48-hour assessment
- daily discharge review
- the role of the liaison worker linked to the ward, and
- the discharge documentation.

#### Key results include:

- a 36% reduction in acute beds which has been re-invested in community services
- a 40% reduction in the length of stay to an average of 20 days, and
- a reduction in the readmission rate from 14% to 8.7% since Jan 2006.

The Trust is also piloting an Assistant Practitioner post to act as the communication link between the inpatient ward and the CRHT, coordinate the review following the 48 hours assessment upon admission and facilitate early discharge. The early indicators are that this is further reducing the length of stay and promoting early discharge.

#### Cumbria Partnership Trust

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More information about lean thinking can be found at [www.lean.org](http://www.lean.org)

Regional CSIP development centres can advise and assist with such redesign exercises. More information can be found at [www.csip.org.uk](http://www.csip.org.uk) In addition, an excellent series of NHS Modernisation Leader guide booklets is available covering general improvement skills, process and systems thinking and personal and organisational development which can be downloaded from: <http://www.wise.nhs.uk/cmsWISE/Tools+and+Techniques/ILG/ILG.htm>

## Care planning and care pathways

### What makes a good care plan?

Timely, safe and appropriate discharge is the result of good care planning and practice throughout the admission. This planning begins at the decision to admit through clarity of purpose and continues with focused care management on the ward, effective joint working with community staff during admission and timely support after discharge.

Care planning in mental health, irrespective of the nature of the problem or the therapeutic approach used, becomes user-focused when the service user and the practitioner develop a shared understanding of what the problems are and agree on goals to guide their working relationship.

Problems and goals are the stepping stone for a care plan, which describes what needs to be done (action) and why and how it may help (rationale). The care plan should be regularly reviewed within specified time periods and based on a clear methodology.

#### The key stages of care planning are therefore:

- defining problems
- setting goals and objectives
- outlining an action plan, and
- reviewing progress.

Mental health has a longstanding system of care planning in the Care Programme Approach (CPA). The CPA is a whole system approach to care planning aimed at ensuring service users have choice of access to a range of services which meet their needs. This should also include addressing housing, employment, leisure and educational needs.

Further information on Choices in Mental Health can be obtained from: [www.mhchoice.org.uk](http://www.mhchoice.org.uk)  
The Single Assessment Process (SAP) is predominantly used for older adults although some local authority areas have adopted SAP for all adult user groups. Some Trusts have adopted care pathway approaches to implement CPA which can reduce bureaucracy and duplication.

### Assessment Care pathway redesign

The Trust took a multi-disciplinary, cross pathway approach which involved process mapping and analysis, developing integrated notes mapped against the desired service user journey and training staff in the use of the assessment pathway. The pathway consisted of the following elements: pre-admission, safety, medical and nursing assessment, investigations, specialist assessment and formulation for the first case review.

#### Key benefits of developing the pathway include:

- clearer engagement during admission
- increased service user satisfaction and involvement in care decisions
- increased service user engagement time
- provided a consistent assessment standard and benchmark across adult acute pathway
- provided a performance monitoring framework
- reduced delays and multiple assessment processes
- strengthened links with crisis resolution and community mental health teams
- more effective use of staff resources, and
- improved care pathway co-ordination and multi-disciplinary care.

#### Newcastle Division, Northumberland, Tyne and Wear NHS Trust

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Source: CSIP NIMHE 10 High Impact Changes for Mental Health Services

### Service user and carer involvement

Service users and carers have a critical role to play in successful care planning, care management and discharge arrangements. Their involvement is an integral part within each of the thematic headings outlined in this document. Successful discharge arrangements are conditional, in particular, on involving them in the following ways:

- sharing of information, in respect of the illness and reasons for admission
- the anticipated length of stay in the inpatient unit
- the process of reviewing patients' progress against goals set, and the arrangements for discharge
- the assessment process, including risk assessment.
- safeguarding and developing key social supports re home, job, education, social networks
- the choice of accommodation, and
- considering the potential of individual budgets and use of advance directives.

### Characteristics of a Capable CPA review

This Carer Group has produced guidelines on ensuring effective user and carer input into an individual's care planning and review meetings, including:

- care co-ordinators should ensure adequate notice is given of the date, time and venue to service users and carers.
- arrangements should ensure the best chance for carer attendance and positive participation, including the opportunity to voice any concerns or opinions
- the carer should get a verbal summary of the plan agreed at the end of the meeting and clarity regarding any roles they are expected to play. This should be followed by a written copy of the plan, and
- the Care Group should ensure an advocate is present if requested.

#### North Notts Carer Strategy Group

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*Everybody's Business: a service development guide for older people with mental health needs* (DH 2005) identified that CPA, SAP and Person Centred Planning (PCP) assessments (used for people with learning disabilities) have several factors in common. The key principles which underpin good care planning, assessment and arrangements for discharge planning are that:

- the service user should be placed at the centre of the assessment and care planning. The service user's views of his/her own abilities and desired outcomes should be central to the process
- each method aims to improve standards of assessment and care planning with a common method across agencies and care settings.
- each method offers a framework for multi-disciplinary and multi-agency working, which aims to help co-ordinate the roles and responsibilities of different professionals across health, social care and other appropriate organisations
- the level and type of assessment should be proportionate to need, and information should be shared and built on, and
- carers are entitled to an assessment in their own right. Their needs and wishes may differ significantly from those of the user but the same principles should apply.

A number of concerns have been identified regarding the variable implementation of CPA including service users and carers' lack of involvement in the care assessment and planning process. In particular many commented on the lack of focus on social care needs and crisis planning which impact significantly on decisions to admit and discharge. A 2004 study (Warner and Hoadley 2004) found that although three quarters of inpatients were known to the service before admission, only half had a current care plan.

In order to address these concerns, the Department of Health has carried out an initial review of CPA policy and practice and issued a national consultation document *Reviewing The Care Programme Approach* (Nov 2006) with a view to simplifying and streamlining the use of CPA. Services to key service user groups are also being reviewed to ensure that they are not overlooked: parents, those with dual diagnosis (substance misuse), the homeless and those with a history of violence or self-harm. The CPA review will also be integrated with the implementation of the White Papers *Choosing Health* and *Our Health, our care, our say*. For more information see [www.nimhe.csip.org.uk/cpa](http://www.nimhe.csip.org.uk/cpa)

Consultation on White Papers: *Independence, Wellbeing and Choice* (DH 2005) and *Our Health, Our Care, Our Say* (DH 2006) highlighted the lack of needs led integrated health and social care assessment. As a result the Department of Health is developing a health and social care Common Assessment Framework (CAF) for all adults with long term or complex conditions to provide a person-centred approach throughout adult life, geared towards self-determination and planning for independence. The framework will build on the experience from implementing CPA, SAP and PCP.

CPA will be incorporated into a Common Assessment Framework for adults as a specialist assessment and the principles of Person-Centred Planning will inform personal health and social care plans. Interdependences between CPA, SAP, PCP and the Common Assessment Framework are being explored through a policy collaborative. For more information see [www.socialcare.csip.org.uk/index.cfm?pid=7](http://www.socialcare.csip.org.uk/index.cfm?pid=7)

## **Implications of the Mental Capacity Act**

The full implementation of the Mental Capacity Act in October 2007 will provide different means by which people who lack capacity (which may be as a result of mental health needs or other causes) can be supported in decisions around their care and treatment. These include enhanced advocacy provision and supported decision making arrangements.

## The Act is underpinned by a series of key principles:

- a presumption of capacity unless it is established otherwise
- the right for individuals to be supported to make their own decisions
- the right to make what might be seen as unwise or eccentric decisions
- anything done for or on behalf of people without capacity must be in their best interests, and
- anything done on behalf of people without capacity should be the least restrictive alternative.

Further information about the Mental Capacity Act and the draft code of practice are available at <http://www.dca.gov.uk/legal-policy/mental-capacity/guidance.htm>

## Advance decisions/directives/wishes/ personal recovery files

The Mental Capacity Act sets out to enable adults who have capacity to do so, to make advance decisions to inform their care plan when they are unwell including how they wish to be cared for in times of crisis.

An advance directive (sometimes called advanced decisions or wishes) is a written document recording the service users' preferences for treatment and care during times when they may be too unwell to contribute such views or make informed choices. They can be useful in both acute mental health and older peoples' services in preventing avoidable admissions or delayed discharges.

Derbyshire Mental Health Services NHS Trust has produced guidelines on development and use of advance directives. The Alzheimer's Society also advocates the importance of advanced directives specifically in care planning for people with dementia. For further information see [www.alzheimers.org.uk](http://www.alzheimers.org.uk)

## Protocol for multidisciplinary discharge planning and monitoring

Haringey Mental Health Partnership Board, comprising NHS and Social Services, has piloted a protocol with timed standards that will apply to acute beds, intensive care beds, and rehabilitation beds for adult and older people services based on multidisciplinary discharge planning and monitoring.

### The main principles are that:

- Once someone no longer requires hospital treatment, he or she should not remain in hospital waiting for arrangements to support him or her in the community to be put in place.
- Discharge planning should start soon after admission, have full multidisciplinary involvement, and should consider both health and social needs of patients
- Decision making about discharge should usually be with both the patient and their carer, although the protocol recognises that this may not always be appropriate.

Following assessment and review, the care coordinator, working with ward staff, will complete the needs assessment and send a written discharge assessment of need notice to the relevant agency (usually Social Services, Housing or Health) as formal notification of a likely need for care services.

### Haringey Mental Health Partnership Board

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A number of inpatient services have developed 'personal recovery file' initiatives where service users complete personal files of key information about themselves and the preferences that they want considered in future care planning decisions. For further information about personal recovery files see [www.starwards.org.uk](http://www.starwards.org.uk)

Increasingly, protocols are being developed to ensure the development of consistent care planning and assessment processes across the service elements of acute mental health care, reduce variation, and improve cross pathway care co-ordination and discharge planning.

A number of Trusts have developed discharge co-ordinator posts/services to support the development of better co-ordinated and timely discharge arrangements. People in these posts/services can be particularly beneficial in organising the care and discharge of people with dementia who may need their mental health care needs attended to while receiving treatment in a general acute care setting, or for people at risk of becoming homeless.

For further good practice on liaison and discharge from general acute services please refer to *Discharge from Hospital, Pathways, Process and Practice* (DH 2003).

### **Rotherham Mental Health Discharge Coordinator for Older People**

The person in this post makes sure there is timely access to appropriate services and improving the assessment process for older people with mental health problems and younger people with dementia. The coordinator provides training in use of assessment and screening tools to be used on general hospital wards. The Coordinator works closely with the multidisciplinary team and the majority of referrals are responded to in 72 hours. Referrals are prioritised based on the risk assessment.

#### **Key results include:**

- 65% of all patients referred to the service returned to their own homes
- throughout the discharge process patient/carer contact was maintained offering expert advice and sign posting to other specialist mental health services, and
- 5% of discharges were successfully accepted for intermediate care. The majority of discharges to intermediate care were patients suffering with anxiety or depression.

#### **Benefits of post include:**

- improved assessment and reduction in avoidable re-admission
- more accurate placements reducing costly revision of care packages
- improved patient and carer experience and satisfaction
- promoted positive changes in personal and organisational culture, and
- better quality of care with appropriate and timely discharge.

### **Doncaster and South Humber Healthcare NHS Trust**

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## Discharge Facilitator initiative (adults)

This initiative aimed to deliver co-ordinated and timely discharge for people having difficulty with benefits or accommodation during their inpatient stay.

The client group were those who were:

- at risk of becoming homeless while receiving inpatient care
- were homeless upon admission or became homeless during their inpatient care, or
- clients whose accommodation needs had changed due to care needs.

3 years ago, average bed occupancy for the trust was 120%, with 25% of available beds occupied by clients experiencing a delayed discharge. In addition around 50 clients were admitted outside of Sheffield.

A review highlighted the following key issues:

- 50% of the delayed discharges were waiting for supported accommodation, benefits and grants applications to support furnishing new homes or securing funding arrangements, and
- there were difficulties in co-ordinating the interfaces between all the services involved in the process.

The aim of the initiative was to:

- prevent people from becoming homeless in the first place by proactively addressing identified issues
- address the needs of homeless people before they are ready to be discharged, to prevent unnecessary delays, and
- where delays were experienced, to reduce the length of the delay.

### Key results:

- bed occupancy levels now below 100%. All Sheffield residents are now admitted locally, with no reliance on out of town referrals
- in the first year, 182 out of 892 admissions benefited from the initiative.
- 67% of those supported did not experience any delay in discharge

- the number of clients experiencing a delayed discharge have reduced by around 40%
- very positive service user feedback
- closer links with the voluntary sector, housing providers, and
- freed up ward time for more therapeutic patient care.

### Sheffield Care Trust

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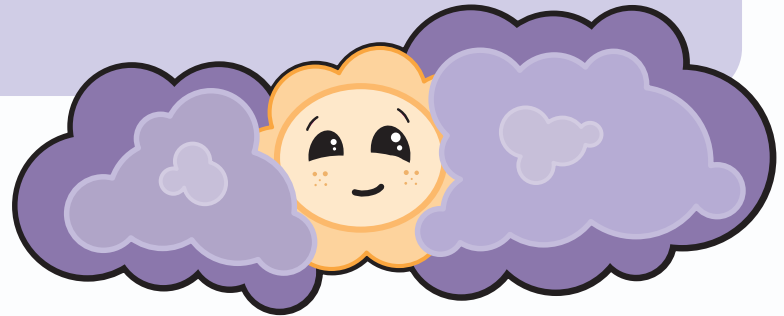
Source: CSIP NIMHE 10 High Impact Changes for Mental Health Services

## KEY MESSAGES

### Whole systems and care planning

- A commitment to whole system working is required to develop a shared understanding of the issues. This works best when all local key stakeholders involved agree a collaborative action plan to reduce delayed discharges.
- The hospital (acute inpatient services) and community components (Crisis Resolution Home Treatment) of the acute care pathway are best delivered when they are effectively integrated, defined and agreed.
- For adult acute mental health services, Acute Care Forums, working closely with their local NSF Local Implementation Teams, are the appropriate vehicle to discuss, devise and deliver local whole system integrated care proposals.
- Streamlining processes and changing practice are as important as investment in capacity.
- Workforce skills are needed regarding service and process redesign, collaborative principles, lean thinking and practice development.

# 3 Admissions management between community based teams and inpatient care



The starting point for considering good practice in discharge needs to be the arrangements for admissions, and in particular the joint working arrangements between community based teams, providing assessment and a gatekeeping role for admissions, and inpatient services.

The role of the Crisis Resolution Home Treatment team (CRHT) is particularly important in adult mental health services as it provides an alternative to inpatient care for many who would otherwise require admission. It also gives staff the opportunity to arrange earlier discharge for people who have been admitted as inpatients.

The CRHT team should assess all potential admissions to inpatient care to determine whether an alternative to inpatient admission is appropriate. Where hospitalisation is required the CRHT team should stay involved in the ongoing care and discharge planning processes to ensure the service user is discharged/ transferred to the least restrictive environment as soon as it is clinically possible (DH 2001).

While good progress has been made and many good practice innovations exist, *The National Survey of Crisis Resolution Home Treatment Teams in England* (Oct 2006) showed that there is still significant development work to be undertaken to ensure the 24 hour availability and effective operation of admissions management and ongoing acute care in all areas. It highlighted that only 68% of CRHT services acted as gatekeeper to admissions and only 53% of teams provided a 24 hour home treatment service. The *DH Guidance Statement on Fidelity and Best Practice for Crisis Resolution Teams* (DH 2006) states that “it is necessary for the CRHT to act as gatekeeper for all people requiring admission to inpatient services” in order to achieve three key outcomes:

- patients should be treated in the least restrictive environment which is consistent with their clinical and safety needs
- inpatient admissions and pressure on beds should be reduced, and
- equity of access to an alternative to admission for patients and families must be ensured.

### Gatekeeping referrals for acute admission

The West Cheshire CRHT team provide a 24 hour gatekeeping function for all referrals to inpatient or community based acute care at home. They screen all potential admissions to determine the optimal level of care in the least restrictive environment. All decisions to admit are subject to a rigorous, multi-disciplinary process focused on outcomes.

Since the team began its work in 2005, there has been a marked reduction in admissions. The mean average monthly admissions in 2004 was 67 with a range of 53 to 80. Since the establishment of CRHT gatekeeping, the mean average has reduced to 36 with a range of 31 to 45. This indicates a 47% reduction in admissions.

#### Cheshire and Wirral Partnership NHS Trust

For further information contact  
[Nigel.crompton@cwprnt.nhs.uk](mailto:Nigel.crompton@cwprnt.nhs.uk)

Clarity about integrated care pathways such as those developed in Newcastle (see page 10, 'Assessment Care pathway redesign') and having criteria for the management of more common mental health conditions are important.

Services need to be clear what qualifies as an 'acute' episode; what requires inpatient psychiatric treatment; what can appropriately be supported by CRHT both in terms of preventing admission and importantly in facilitating early discharge for continuing acute treatment at home /in the community; and what are the trigger events or signs that require transfer from crisis resolution to acute inpatient care.

This means there is a need for a regular dialogue and case review between the CRHT team and the acute inpatient service. This should begin with the CRHT team providing information to the acute ward for each admission:

- detailing the purpose of the inpatient admission
- agreeing an estimate of its expected duration (within a range if necessary), and
- providing regular input into the care plan and its review while the service user is an inpatient.

### Whole system approach

There is now a whole system approach to acute care. The catchment area for the previous trust had two CRHT teams, incorporating the gatekeeping of admissions to inpatient care and dedicated medical staff, who also continue to work with people when they are admitted. This has resulted in a 33% reduction in use of acute beds and an increase in early discharge from hospital. The integration of acute care across crisis assessment and treatment and inpatient services has also had a very favourable response from service users and carers.

#### Surrey and Borders Partnership NHS Trust

For further information contact  
[mike.poulter@sabp.nhs.uk](mailto:mike.poulter@sabp.nhs.uk)

Source: South East Acute Care Collaborative benchmark and positive practice initiatives

Initiatives such as 'purposeful admission' and the setting of target dates following admission to begin active discharge planning and maximum length of stay criteria, are being successfully adopted within many mental health Trusts.

With proper gatekeeping of admissions, the CRHT team should be clear about why each admission was necessary. Facilitating early discharge by improved integration of CRHT and inpatient services may be assisted by the use of specific discharge documentation shared between the CRHT team and the ward that specifies the reason for admission to hospital and what needs to be resolved before discharge can be considered.

In many cases, resolution of practical issues in the community will enable the early discharge of a service user whose acute treatment episode can then be treated at home or in the community. The SCMH publication *Crisis Resolution and Home Treatment – a practical guide* (SCMH 2006) includes an exemplar early discharge proforma.

Relevant factors and the benefits of achieving operational integration of crisis resolution home treatment and acute inpatient services as identified by M Smyth (2003) include:

- structured linkages between CRHT and inpatient care from the beginning are important (rather than trying to establish them at some future point)
- admission pressures on inpatient care are reduced, allowing more time to develop inpatient therapeutic relationships and deliver structured care plans
- inpatient awareness of social and community factors influencing the care plan is assisted, as is more explicit awareness of why the admission was appropriate and under what circumstances it needs to continue
- operational policies might include CRHT attendance at ward rounds, routine screening for early discharge, joint acute care reviews etc. Although a shared operational policy is important, it is key that there is a shared value base and mutuality. Joint working is easier, for example, if teams share the same base location, and
- lead consultant responsibility in both settings assists integration.

*“An emerging theme is that ease of collaboration is inversely proportional to the number of consultants linked to each CRHT team and ward.”*

(Smyth 2003)

*“Opportunities to develop single management and staff team arrangements across acute care services need to be pursued”*

(DH 2002)

### **Redesigning services for Nabcroft Older Peoples Service Kirklees**

This initiative aimed to strengthen the 7 day a week interventions offered by a range of community teams included:

- prolonged and intensive community support for people with severe and enduring needs
- brief interventions in support of other professionals, for people with less severe or enduring needs, and
- a reduction in Day Hospital places and formation of an Outreach Team that offered alternatives to inpatient admission, whilst in-reaching to wards to facilitate earlier discharge.

#### **Key benefits include:**

- a 27% reduction in beds has been maintained with bed occupancy rates below 100%
- 72% of CMHT caseload is in the severe and enduring needs target group
- the revised day service is targeted on people with more severe and enduring mental health problems.
- 63% of people attending the day hospital indicated they would be satisfied attending on a sessional basis rather than a full day, and
- there is increased capacity for home based care with service users now choosing intensive support at home rather than hospital admission.

#### **South West Yorkshire Mental Health Trust**

For more details contact [ben.boyd@swyt.nhs.uk](mailto:ben.boyd@swyt.nhs.uk)

Source: CSIP NIMHE 10 High Impact Changes for Mental Health Services

There are a number of positive practice examples where single structure service co-ordination and management arrangements have been put in place that have led to significant improvement in use of inpatient beds and an increase in earlier discharge from hospital.

### **Acute inpatient care within a whole systems approach.**

As part of the Sainsbury Acute Solutions project the Meadowfield Unit in Worthing established a learning set with enough seniority to challenge current models and develop new ideas. The group focused on establishing a shared understanding of current services which contributed to developing an overarching operational policy and individualised care pathways for people with complex needs.

#### **Key benefits include:**

- the inpatient unit has a clearly defined purpose and operational policy, including interfaces with CRHT and other key services. This has been agreed across the service and with commissioners.
- the hospital and community elements of the service have a single management structure.
- there is a practical application of whole systems working for the care of a limited number of people with complex needs, and
- a need was identified to develop commissioning arrangements to meet specific needs eg learning disabilities, challenging behavior, complex needs.

#### **Sussex Partnership Trust**

For further information contact:

*seamus.watson@sussexpartnership.nhs.uk*

Source: SCMH The Search for Acute Solutions

### **Integrated Acute Care service**

The Trust has integrated its inpatient and crisis services into one team in Waveney and Great Yarmouth. This has resulted in a significant reduction in the bed occupancy rates of both sites. Staffing comes from a pool of staff who work between acute inpatient care and CRHT. The base for the crisis service is also located within the same building as the acute inpatient service.

#### **Norfolk and Waveney MH Trust**

For further information local contact:

*patrick.mcglynn@nemhpt.nhs.uk*

#### **Other examples**

- Kings Lynn has integrated its acute inpatient service with the Day Hospital and CRHT teams. For details contact *patrick.mcglynn@nemhpt.nhs.uk*
- East Surrey has integrated its acute and CRHT service. Staff work across the pathway 2 days per week with CRHT and 3 days on the acute ward. For details contact *mike.poulter@csip.org.uk*

### **Crisis houses**

Crisis houses, often provided in partnership with local community and voluntary sector organisations, supported by CRHT services offer short term intensive support for people who might otherwise require a hospital admission or the potential for earlier discharge from inpatient care. A number of services have found they are particularly helpful in responding to specific needs of women in crisis, people from minority ethnic communities and people with personality disorder problems.

A Medical Research Council pilot study (MRC 2006) is currently being undertaken evaluating admission to women's crisis house provision compared with acute inpatient admission. For further information contact *l.howard@iop.kcil.ac*

### **Crisis service for women – Drayton Park Crisis House**

The service is unique in providing a service to women in crisis and their children. If women are offered admission they are offered a week initially and up to a maximum of a four week stay. This keeps the focus of the work on the crisis and keeps the community systems engaged. The service helps women find new ways of coping with their mental health problems including crisis containment and reduces dependence on hospital admission.

### **Camden and Islington Mental Health and Social Care Trust**

For further information local contact:  
*Shirley.McNicholas@candi.nhs.uk*

### **The Haven Project**

This is a voluntary sector agency dedicated to the support and treatment of people with a personality disorder in the Colchester, Tendring peninsula and Halstead areas in Essex. The project combines a full day service programme with crisis services that are available 24 hours 7 days per week. It has 110 registered service users and on average provides 1600 contacts per month. Service users play a central role in the shaping and running of the service.

### **Impact on service delivery**

- reduction in the use of the MHA Section 136 by 87%
- acute inpatient admissions reduced by 85%, and
- use of A&E services reduced by 60%.

For further information contact:  
*heather.castillo@thehavenproject.org.uk*

Source: CSIP 10 High Impact Changes for Mental Health Services

For further information on personality disorder:  
*www.personalitydisorder.org* and the publication *Personality Disorder – No longer a diagnosis of exclusion* (DH 2003).

## **Acute day care**

Evidence suggests that day care, when clearly defined as a component of the acute care pathway, can play an important role in preventing admission and facilitating early discharge for people who are otherwise at risk of admission to acute mental health inpatient care (Priebe 2006).

### **Banbury 7 day a week acute day hospital**

The day hospital has been set up as a multi disciplinary assessment and treatment service for people who are acutely unwell and at risk of admission to hospital. The service is available 9-5, 7 days a week. Around 45% of service users are referred from the CRHT service and are jointly managed with the day hospital. In addition to providing an alternative to admission, the service works to provide recovery and inclusion and facilitate early discharge. The initial review of the service indicates that 71% of those assessed and treated by the day unit would otherwise have required an inpatient admission.

### **Oxfordshire and Buckinghamshire Mental Health Partnership Trust**

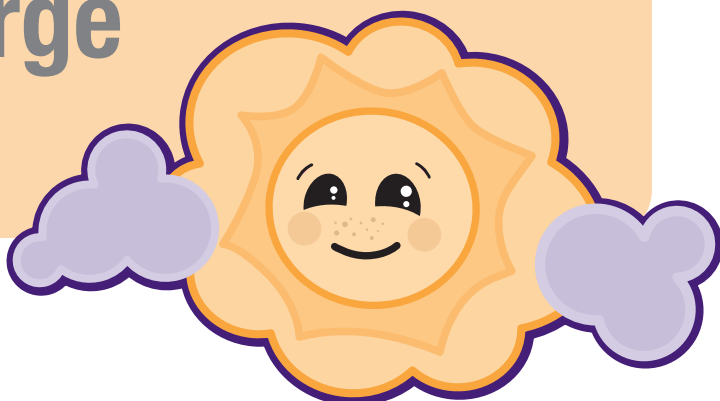
For further information contact:  
*jon.allen@oxmhc-tr.nhs.uk*

## KEY MESSAGES

### Admissions management

- Agreed inter-agency integrated care protocols, which incorporate the purpose of admission and the role of the acute ward will improve service co-ordination.
- The CRHT service should gatekeep all acute admissions and provide access to a 24/7 service. The CRHT should also have a clear role in facilitating early discharges.
- Effective single system 24 hour admissions management and joint care arrangements need strengthening, particularly between CRHT and acute inpatient wards.
- The reasons for admission should be clearly documented and an expected date of discharge should be set at admission. Addressing these issues should be proactively managed against the care plan.
- Service user and carer input is central to all aspects of discharge planning arrangements. There is a need to maximise the potential of direct payments, advance directives and advocacy.
- Timely, safe and appropriate discharge is the result of good care planning from the decision to admit to providing post discharge support.
- Single management and staff team arrangements will help deliver integrated care solutions.
- The development of less restrictive alternatives to inpatient admission such as crisis or respite houses and acute focused day services will help to reduce unnecessary inappropriate admissions and promote early discharge.

# 4 Consistency in risk assessment and discharge planning



Discharge planning should be an inherent part of the decision to admit. Critical to good care planning must be a multi-professional comprehensive risk assessment informing the decision to admit and identifying when discharge readiness may be achieved.

This requires early information sharing and clear communication between the services involved, members of the multi-disciplinary team, service user and carer and required community support agencies. Effective admission assessment processes can highlight care issues that require prompt intervention so they do not protract the length of stay and delay the discharge.

The initial stage to discharge planning is a comprehensive risk assessment, including liaison between the Care Co-ordinator and the community team responsible for continuity of care and an informed service user history. Links with carers, relatives and wider support networks that individuals may have are also critical, as highlighted in *From values to action: the Chief Nursing Officer's review of mental health nursing* (DH 2006).

## Admission assessment process

Meadowfield and Centurion inpatient units have developed a new approach to admission assessments. The main admission assessment has been separated into:

- an initial assessment which incorporates the SHO's history and present mental state assessment, risk assessment, physical assessment and examination, inpatient nursing assessment focusing on immediate needs and an initial 72 hour care plan, and
- a multi-disciplinary needs and mental health assessment is completed within the first 7 days of admission. This assessment is based on the stress vulnerability model thereby understanding the factors which may have contributed to the deterioration in the person's mental health

Following the development of a training programme, this assessment model is now used within both acute inpatient units.

### Sussex Partnership Trust

For details contact:

[Theresa.Dorey@sussexpartnership.nhs.uk](mailto:Theresa.Dorey@sussexpartnership.nhs.uk)

Evidenced based structured tools can aid professional decision making in assessing need. There are a number of tools that have been developed to assist the process of establishing and monitoring care pathways and appropriate packages of care. One example is the Crisis Triage Resolution System (CTRS).

This is an established triage tool for crisis admission, which looks at a variety of service user indicators including symptoms, social support and ability to engage.

Further information on the use of these tools and best practice can be found at [www.csip.org](http://www.csip.org). The consistent use of such assessment tools by staff across the elements of the acute care service will promote integrated decision making and care delivery.

### Risk assessment and discharge planning

Risk assessment and discharge planning, including psychological and social factors should be a continuous process which needs to incorporate appropriate periodic reassessment of risk, in partnership with the service user.

*“In practice, assessments often concentrate on clinical needs and fail to address social needs such as housing, employment, income or social networks. In fact these factors are crucially relevant in terms of both the presenting problem and the treatment approach”*

(DH 2004)

## Service redesign to reduce admissions and variation in discharges

Extreme pressure on Southwark acute beds resulted in 37% of admissions to the private sector. This was reversed with the introduction of CRHT teams. A comprehensive audit of ward activity identified the causes of delayed discharges and highlighted significant differences in length of stay, clinical practice and leadership between wards.

### Key actions taken include:

- a weekly bed management meeting for inpatient and community teams
- use of statistical process control charts to clarify required bed capacity
- CRHT teams gate-keep all admissions and expedite early discharge
- development of a new bed management database to manage activity
- introduction of a daily bed management handover report, and
- HoNOS used to evidence improvements in health outcomes.

### Key results include:

- reduced admission rate and length of stay
- fewer delayed discharges
- easier access to beds when required
- no private sector placements
- a reduced re-admission rate which is better than the national average or for similar Trusts, and
- a reduction in bed numbers with the financial savings used to provide single sex wards.

### South London and Maudsley NHS Foundation Trust

#### For further information contact:

[Kevin.smith@slam.nhs.uk](mailto:Kevin.smith@slam.nhs.uk)

Source: CSIP 10 High Impact Changes for Mental Health Services

## Solution Focused Approaches (SFA)

In North Staffordshire, the acute unit liaises closely with, and is visited regularly by, members of the CRHT who take a Solution Focused Approach (SFA) to transfer home using the signs of wellbeing model developed locally. The majority of staff on acute wards have received SFA training through the Trust programme and this helps to achieve the earliest possible discharge. The trust also has a nationally recognised CPA system, highly developed inter-disciplinary working, and an organisational culture underpinned by SFA.

### North Staffordshire Combined Healthcare NHS Trust

For further information local contact:  
[steve.freeman@northstaffs.nhs.uk](mailto:steve.freeman@northstaffs.nhs.uk)

More information on solution focused approaches can be obtained via [www.solutionfocusedapproaches.co.uk](http://www.solutionfocusedapproaches.co.uk)

The fact that very many service users will be discharged home to the care of families, relatives and friends should always be borne in mind. It is crucial that staff responsible for assessing risk and planning discharge consult with people who know the service user well, if possible, before they became ill and required hospital treatment. Discharge is a process which should happen evenly across all days of the week, rather than being focused on Fridays, and needs to occur earlier in the day before the peak demand occurs for admission.

Individuals have biographies and histories that are important in maintaining their sense of self and providing insights into their social functioning. This is particularly important for older people with dementia, who may have been managing at home in the community despite their mental impairment and may present very differently in the unfamiliar environment of a psychiatric ward.

The assessment process must also include an assessment of the physical health of the service user. Levels of poor physical health amongst users of mental health services are well documented and can be a factor in extending the length of stay on the acute ward. A full physical examination should be undertaken to inform the care plan and to ensure any physical health problems are promptly attended to.

There are particularly complex discharge planning issues for service users with 'dual diagnosis' (co-morbid mental health and substance use problems) which are highlighted in "Dual diagnosis in mental health inpatient and day hospital settings" (2006) Service users with drug or alcohol problems often have an increased risk of overdose, suicide or violence to others upon discharge which require rapid follow-up arrangements to be put in place as part of CPA. Treatment plans and discharge arrangements also need to take account of the external environment to which the service user is returning and the risk of relapse. Discharge planning is often complicated by the potential lack of available housing options. Many housing providers will not take tenants with known substance use problems which cause increased delays in discharge. It is therefore critically important to ensure that there is a full multi-disciplinary care plan in place which takes account of substance use issues and that robust links exist with all relevant agencies, especially housing providers.

### Dual Diagnosis training package

A 5 day dual diagnosis training package, developed by the Institute of Psychiatry, is being disseminated across London Trusts with the support of the CSIP London Development Centre. The training aims to equip staff with the capabilities required to work with this group of service users. It highlights the importance of inter agency collaboration and in some areas training has been provided to mixed range of agencies (eg mental health, substance misuse, housing, social care). Training inpatient staff increases the likelihood of service users' substance use being addressed during admission and it is hoped that as staff from the housing/hostel sector become better equipped to work with this group they will be more willing to accept people with a dual diagnosis for placement.

#### CSIP London Development Centre

For further information contact:

*Cheryl.kipping@londondevelopmentcentre.org*

An essential part of good discharge planning is to ensure that the discharge information is sent to the GP prior to the service user's discharge from hospital. A number of studies show that a significant proportion of service users contact their GP before the discharge information is received which potentially increases the risk of relapse.

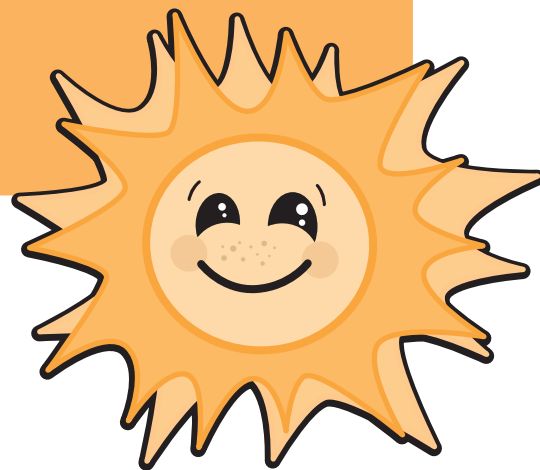
Equally important is the need for effective medication management at the point of discharge to ensure that service users get clear medication information. For more information see the Medicines Management practice example on page 28.

### KEY MESSAGES

#### Risk assessment and discharge planning

- It is important that the same evidence based continuous risk assessment processes are consistently applied across the care pathway.
- It is important to ensure that the practical and social reasons influencing the admission have been addressed.
- Specific attention should be given to ensuring staff competence in the care and discharge planning for service users with 'dual diagnosis' problems.
- Specific discharge co-ordinator posts can help organise and expedite discharge arrangements across the service system.
- Medicines management should be a core component of discharge planning.
- Discharge information should be sent to the GP prior to the service user's discharge from hospital.
- Service users with 'dual diagnosis' problems, the homeless, and those with a history of violence or self-harm are especially vulnerable and need rapid follow-up arrangements to be put in place.

# 5 Focusing ward arrangements



In addition to effective integrated joint working across the acute care pathway being a cornerstone of early and appropriate inpatient care planning and effective discharge, this section considers a number of further key areas impacting on discharge arrangements.

## Ward rounds/patient review arrangements

Traditionally, much discharge-related dialogue within the multi-disciplinary team and with the service user/carer is associated with the consultant ward round. Inefficient scheduling of such review processes protract the stay of patients otherwise ready for discharge.

Ward rounds typically occur weekly with all relevant professionals involved besides the Care Co-ordinator. Careful thought is required about the organisation of ward rounds or alternative review arrangements to take account of the needs and preferences of service users which also ensures the best use of resources and the effective running of the ward.

## In-Patient Consultant appointment times for mental health service users.

The Trust undertook a review of ward rounds, following concern fed back from service users about the amount of staff involved in their ward rounds.

As a result, consultant appointments are given to service users to discuss issues with the consultant, a ward nurse and SHO. Each service user is allocated a 30 minute slot on the designated day for the purpose of seeing his/her own consultant and SHO who both review his/her current mental health state via the information provided by the ward round nurse and the service user. A review of current medication, side effects and investigations/tests which have been reported is also carried out. All present parties negotiate and agree a care/treatment plan for the forthcoming week. All plans are then communicated to ward staff both verbally and in written form via the ward round nurse. This allows information to be shared ensuring continuity of care.

CPA multidisciplinary reviews are conducted by the service user's individual team. All disciplines involved are invited to attend, and the meeting takes place on a different day so that service users still have the allocated time with the consultant.

**Tees, Esk and Wear Valley NHS Trust**

For details contact: [Kelly.murray@tney.northy.nhs.uk](mailto:Kelly.murray@tney.northy.nhs.uk)

## Alternative approach to ward rounds

An alternative approach to ward rounds has been piloted by Vaughan Thomas Ward in Wareford Hospital. The 5 consultants admitting to a ward replaced individual ward rounds with a single ward round day per week. On that day all consultants attend the ward and link with the care co-ordinators to review the service user's care plan. This has freed up ward staff time to engage with service users and has been welcomed by service users and staff.

### **Oxfordshire and Buckinghamshire Mental Health Partnership Trust**

**For further information contact:**  
*jon.allen@oxmhc-tr.nhs.uk*

### **Other alternative approaches include:**

- Berkshire Healthcare Trust has introduced a weekly multi-disciplinary review meeting for each locality replacing 5 weekly ward rounds and releasing staff time to engage in other therapeutic and care planning activities. This is being rolled out across other acute wards.

### **Berkshire Healthcare NHS Trust**

**For further information contact:**  
*cris.spring@berkshire.nhs.uk*

- Broadoak Unit in Liverpool has developed a code of good practice for ward reviews aimed at making ward reviews more service user and carer friendly. Staff are expected to spend time with each service user prior to each review to document their views, identify any problems and find out what service users want raising at the review. A copy of the decisions of the review and actions to be taken are given to the service user.

### **Merseycare NHS Trust**

**For further information contact**  
*Eifion.Ingman@merseycare.nhs.uk*

## New Roles and New Ways of Working

There have been a number of new roles introduced to facilitate the implementation of the NSF along with a major review of existing roles as part of CSIP's National Workforce Programme – New Ways of Working (NWW).

It is important that the local introduction and implementation of such posts as Support, Time and Recovery (STR) workers and Community Development Workers (CDW) ensure specific remits for working with acute inpatient services. These roles are valuable in assisting the cultural competence of services, in promoting the recovery and social inclusion of service users while they are inpatients and in enhancing their opportunities post discharge. See page 27 for an innovative approach to recruiting STR workers in North East Lincolnshire.

An aim of the NWW initiative is to develop closer links pre and post admission to improve continuity of care and free up nursing time for therapeutic engagement. There are a number of examples in this section which demonstrate how new roles and NWW can assist the achievement of care plan goals and effective discharge arrangements.

## Consultant psychiatrist roles

In line with the Acute Care Mental Health Policy Implementation Guide recommendation, some Mental Health Trusts have reorganised their consultant psychiatrists to have a single acute lead consultant, responsible for inpatients, with the other consultants providing a community-focused, home support service. This approach has the advantage of focusing acute-based support activity on a single consultant, providing a single, flexible pool of inpatient beds and clear arrangements regarding discharge processes and decision making.

## North East Lincolnshire's Support Time Recovery Workers

The Support Time Recovery Workers (STRWs) operate within the home treatment service, supporting people who are on home treatment package and those on early discharge. The whole service focuses on alternatives to admission, and where there isn't an alternative, then early discharge. The STRWs proactively engage with individuals using the recovery model and strengths based approach.

50% of STRWs across the service are service users. The Trust was flexible in employment re hours worked per week and the time of working where possible. All have individual supervisors for clinical supervision and monthly group supervision. A key consideration in introducing this new role was to engage with the Human Resources Dept, and, in particular, Occupational Health (around fitness to work ). There was also strong leadership and support regarding the benefits of this role and the employment of service users.

North East Lincolnshire has recently seen a reduction in bed occupancy and length of stay, which is due in part to STR work as well as a change in approach across the service area.

### North East Lincolnshire PCT

For further information contact:

*Jacqui.ellis@nelpct.nhs.uk*

## Lead nurse consultants, modern matrons and nurse practitioners

The recent Chief Nursing Officers review of mental health nursing (DH 2006) makes a number of specific recommendations for improving inpatient care including the need to further develop shared roles and training between inpatient and CRHT staff. The appointment of nurse leadership posts such as lead nurse consultants with responsibilities across local acute care services and modern matron posts have been instrumental in developing many of the positive practice examples in this guide.

## Lead consultant roles

In line with a major service review and change programme consultant psychiatrists have peer reviewed their roles and workload and agreed role changes as part of an overall service redesign process. As a result the consultants in Newcastle moved from generic to specialist roles and work exclusively with either in-patient and crisis teams or community multidisciplinary teams. Specialist consultants are able to focus on their particular area of service.

This enables:

- strong clinical leadership and direction
- easy access for the patient to an expert assessment and review
- easy availability of support, discussion and supervision to members of the multi-disciplinary team (MDT), other specialists and primary care
- better joint working between senior professionals and managers, and
- greater availability of supervision and training of junior medical staff and other staff.

Changes are planned for the junior doctors' roles and job plans.

### Newcastle Division, Northumberland, Tyne and Wear NHS Trust

For further information contact:

*Suresh.Joseph@nmht.nhs.uk*

## Extended roles of pharmacy in medicines management

Many studies have identified admission and discharge from hospital as two periods where medicine errors commonly occur. Such errors can delay discharge or lead to otherwise preventable re-admissions. To expedite more rapid recovery and self-management in the community service users should receive clear discharge and post discharge medication information. This information should be included in CPA documentation.

## Medicines management

The 'Near Patient Discharge Project' reviewed, assessed and redesigned two areas in the patient discharge system:

- information supplied on discharge – to ensure that all parties including service users receive appropriate information about medicines, and
- counselling and concordance – to increase the likelihood of service users taking the medicines appropriately once discharged.

The success of this initiative has led to a change in how the pharmacy service to the acute wards is provided, a greater integration of the pharmacy staff into the ward team and has had very positive feedback from service users and staff.

### **Derbyshire Mental Health Services NHS Trust**

**For further information contact:**

*david.branford@derbysmhservices.nhs.uk*

## Use of feedback information/performance indicators

Increasingly, mental health Trusts are collating and using data on service use to identify trends and bottlenecks, promote discussion and analysis amongst multi-disciplinary or multi-agency teams/ACFs and contribute to local thinking about service improvement and reducing delayed discharges. These include:

- using the DH situation reports (SITREPS) delayed transfers of care categories for recording the reasons and overall numbers of mental health delays which is now compulsory for all mental health trusts. In Gloucestershire, the mental health Trust is represented at the monthly countywide meeting to review inpatient delayed transfers
- monitoring of long lengths of stay above a certain threshold, to review the circumstances and any trends that emerge, and
- monitoring of psychiatric readmission rates (within 90 days for example).

The SCMH CRHT practical guide (2006) recommends collecting and monitoring the following baseline data to track early discharge to the CRHT:

- number of admission by consultant/sector
- average length of stay
- number of referrals from the ward
- referrals accepted for early discharge, and
- early discharges as a proportion of CRHT caseload.

## Bed management database and bed management system

A new bed management database was developed in the Southwark locality of the South London and Maudsley NHS Foundation Trust. The system is accessible to all clinical team leaders, medical staff and managers. It is now the primary system for managing admissions and discharges and for providing the information required to manage service performance. All admissions are screened by CRHT who also facilitate early discharge. Demand and capacity are monitored via a weekly problem solving bed management meeting which is led by the Inpatient Services Manager/Clinical Director and informed by activity recorded on the database.

### **South London and Maudsley NHS Foundation Trust**

**For further information contact:**

*Kevin.smith@slam.nhs.uk*

## Social inclusion and recovery

Social inclusion and active community participation for mental health inpatients is key to reducing loss of social contacts (a major contributor to prolonged lengths of stay) and promoting recovery. There is a strong link between delayed discharge for mental health inpatients and the risk of social exclusion. Protracted lengths of stay can lead to loss of job, risks to tenancy, breakdown in relationships, and loss of social networks. However, opportunities for active community participation can be promoted from a mental health inpatient environment.

## Social inclusion initiatives

Berkshire Healthcare NHS Trust has developed a package of initiatives which includes:

- inviting past service users to volunteer on acute wards
- employing a welfare officer who has developed strong links with benefit offices
- jointly working with Newbury College to provide service users a training programme of learning and social inclusion (Newbury CMHT)
- utilising community, sports and leisure facilities near the hospital as well as a hospital gym, and
- establishing links with the local mental health liaison police inspectors.

### **Berkshire Healthcare NHS Trust**

**For further information contact:**

*cris.spring@berkshire.nhs.uk*

## Access to out of hours leisure and educational activities

A local consultation with service users highlighted how important it was to have access to leisure activities especially during the evenings and at weekend. Doncaster set about recruiting people from the community with specific interests in order to provide a range of out of hours and weekend diversional/recreational activities on a one-to-one and group basis both in hospital and in the local community. Examples include massage, juggling, manicures, painting, language lessons, drama, photography, theatre trips, and poetry. Service users have been active partners in the recruitment and planning the activities programme. This has proved to be very successful, cost effective and sustainable.

### **Doncaster and South Humber Healthcare NHS Trust**

**For further information contact:**

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There are benefits from proactive engagement with local recovery based services and relevant community groups to assist in promoting effective discharge and in avoiding the revolving door syndrome.

Relevant partners include local service user and carer groups, voluntary organisations, the local Learning and Skills Council, Further Education Colleges, Job Centres, sports and leisure services and Citizens Advice Bureaux which can be brought onto the ward environment or involved in outreach schemes. Specific attention should be given to the needs of younger service users through liaison with Early Intervention Services and Connections.

The key focus of positive acute mental health care should be to promote the service user's individual recovery. A number of self-management recovery tools have been developed which are highly rated by service users. One tool is the Wellness, Recovery and Action Plan (WRAP) This is a self-management and recovery system developed by people with mental health problems, which attempts to incorporate wellness tools and strategies into everyday life. For more information see <http://www.copelandcenter.com/index.php>

Another useful tool for assessing the service user's commitment to recovery is the Developing Recovery Enhancing Environments Measure (DREEM). For more information on this see <http://www.nimhe.csip.org.uk/silo/files/dreem-total-dft4-no-tc-1.pdf>

## Post-discharge services and facilities

### Access to accommodation and supporting services

A key component of timely discharge is having access to accommodation and a range of supporting services and facilities to meet the needs of service users. This includes the need to keep service users connected to appropriate networks outside the inpatient unit as part of their recovery, as this will assist effective discharge, promote recovery and help prevent re-admission.

Returning home from hospital can be a stressful time for people with mental health problems, especially if the hospital stay has been prolonged. The longer the service user remains an inpatient the greater the likelihood of creating dependence on inpatient care and of potential readmission.

Staff responsible for planning discharge should ensure that:

- service users and their carers have clear information about follow up arrangements – home visits, out patient appointments, day hospital attendance, group sessions, repeat prescriptions
- GPs receive prompt information about treatment, medication and follow up
- for people on CPA, the Care Co-ordinator is appointed well in advance of discharge and arrangements are clear about future contact, risk management and home care arrangements, and
- housing, employment, educational/vocational, and benefit entitlement needs have been attended to and put in place.

### The Hartlepool post discharge service

This service was developed after the NSF for mental health highlighted that people are more at risk from suicide within the first seven days after discharge from hospital care. The service ensures a comprehensive package of care tailored for the individual client and their carers.

The service offers short home visits to alleviate anxiety. All people who have been an inpatient within the mental health unit are visited at home within seven days and those who are deemed high risk within forty eight hours. Individuals have said visits by someone familiar and reliable have reduced their worries about returning to the community.

The service aims to optimise engagement, prevent or anticipate crisis and reduce risk. Ensuring the availability of a comprehensive package of community based care has had significant impact on psychiatric readmission rate within the Hartlepool locality.

#### Tees, Esk and Wear Valley NHS Trust

For further information contact:  
[janet.simpson@tney.northy.nhs.uk](mailto:janet.simpson@tney.northy.nhs.uk)

### KEY MESSAGES

#### Focusing ward arrangements

- Clear clinical leadership arrangements should be in place.
- The role of the consultants, their engagement and commitment to improving the acute care pathway, and new ways of working are crucial. Ownership and leadership from Trust Board are also needed.
- The process of ward reviews/ward rounds need to ensure the most effective use of resources to maximise therapeutic engagement time.
- The opportunities provided to review existing roles as part of New Ways of Working and the introduction of new roles should be exploited to address current weaknesses and deficits.
- In order to develop an integrated approach, training and development should focus on whole team training which includes CRHT and acute inpatient staff.
- Information systems should be in place locally to inform and monitor efforts to reduce discharge delays.
- Inpatient services should have clear working arrangements with local accommodation providers and community organisations to help keep service users connected to their social networks which will promote recovery.
- A focus on recovery approaches, social inclusion and community engagement is needed throughout the acute care pathway to promote individual recovery.

## Appendix A: Summary of positive practice examples

No	Example	Organisation	E-mail contact
1	Acute Care Forum	Cheshire & Wirral Partnership Trust	Nigel.crompton@cwprnt.nhs.uk
2	Lean thinking approach	Cumbria Partnership Trust	Karen.holt@cumbria.nhs.uk
3	Assessment Care Pathway Redesign	Northumberland Tyne & Wear NHS Trust	Angus.forsyth@nmht.nhs.uk
4	Characteristics of a capable CPA review	North Notts Carer Strategy Group	Mark.varney@nottshc.nhs.uk
5	Multidisciplinary Discharge planning & monitoring protocol	Haringey MH Partnership Board	Antony.adkin@beh-mht.nhs.uk
6	MH Discharge Coordinator older people	Doncaster & South Humber Healthcare NHS Trust	joanne.lifsey@dsh.nhs.uk
7	Discharge Facilitator Initiative	Sheffield Care Trust	Lenny.fairhall@sct.nhs.uk
8	Gatekeeping acute admission referrals	Cheshire & Wirral Partnership Trust	Nigel.crompton@cwprnt.nhs.uk
9	Whole System Approach	Surrey & Borders Partnership Trust	Mike.poulter@csip.org.uk
10	Redesigning services for older people	South West Yorkshire NHS Trust	Ben.boyd@swyt.nhs.uk
11	Acute inpatient care within a whole system approach	Sussex Partnership Trust	Seamus.watson@sussexpartnership.nhs.uk
12	Integrated acute care service	<ul style="list-style-type: none"> <li>• Norfolk &amp; Waveney MH Trust</li> <li>• Kings Lynn</li> <li>• East Surrey</li> </ul>	Patrick.mcglynn@nemhpt.nhs.uk Patrick.mcglynn@nemhpt.nhs.uk Mike.poulter@csip.org.uk
13	Crisis service for women	Camden & Islington MH & Social Care Trust	Shirley.mcnicholas@candi.nhs.uk
14	Haven Project for people with personality disorder	North Essex MH Partnership NHS Trust	Heather.castillo@thehavenproject.org.uk
15	Banbury 7 day a week acute day service	Oxford & Buckinghamshire MH Partnership Trust	Jon.allen@oxmhc-tr.nhs.uk
16	Admission assessment process	Sussex Partnership NHS Trust	Theresa.dorey@sussexpartnership.nhs.uk
17	Service redesign to reduce admissions and variation in discharges	South London & Maudsley NHS Foundation Trust	Kevin.smith@slam.nhs.uk
18	Solution Focused Approaches	North Staffordshire Combined Healthcare NHS Trust	Steve.freeman@northstaffs.nhs.uk
19	Dual Diagnosis Training	CSIP London Development Centre	Cheryl.kippling@londondevelopmentcentre.org
20	Inpatient consultant service user appointment times	Tees, Esk & Wear Valley NHS Trust	Kelly.murray@tney.northy.nhs.uk
21	Alternative approaches to ward rounds	<ul style="list-style-type: none"> <li>• Oxford &amp; Buckinghamshire MH Partnership Trust</li> <li>• Berkshire Healthcare NHS Trust</li> <li>• Merseycare NHS Trust</li> </ul>	Jon.allen@oxmhc-tr.nhs.uk Cris.spring@berkshire.nhs.uk Eifion.Ingman@merseycare.nhs.uk
22	NE Lincs Support, Time and Recovery Workers	North East Lincolnshire PCT	Jacqui.ellis@nelpct.nhs.uk
23	Lead Consultant roles	Northumberland Tyne & Wear NHS Trust	Suresh.joseph@nmht.nhs.uk
24	Medicines Management	Derbyshire MH Services Trust	David.branford@derbysmhservices.nhs.uk
25	Bed management system and database	South London & Maudsley NHS Foundation Trust	Kevin.smith@slam.nhs.uk
26	Social Inclusion initiatives	Berkshire Healthcare NHS Trust	Cris.spring@berkshire.nhs.uk
27	Access to out of hours leisure and educational activities	Doncaster & South Humber Healthcare NHS Trust	Deborah.wildgoose@rotherhampct.nhs.uk
28	Hartlepool post discharge service	Tees, Esk & Wear Valley NHS Trust	Janet.simpson@tney.northy.nhs.uk

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## Glossary

<b>ACF</b>	Acute Care Forum
<b>CAF</b>	Common Assessment Framework
<b>CDW</b>	Community Development Worker
<b>CMHT</b>	Community Mental Health Team
<b>CPA</b>	Care Programme Approach
<b>CRHT</b>	Crisis Resolution Home Treatment
<b>CSIP</b>	Care Services Improvement Partnership
<b>CTRS</b>	Crisis Triage Resolution System
<b>DH</b>	Department of Health
<b>DREEM</b>	The Developing Recovery Enhancing Environments Measure
<b>LIT</b>	Local Implementation Team
<b>MDT</b>	Multidisciplinary Team
<b>MHAC</b>	Mental Health Act Commission
<b>MHPIG</b>	Mental Health Policy Implementation Guide
<b>MRC</b>	Medical Research Council
<b>NSF</b>	National Service Framework
<b>PCP</b>	Person Centred Planning
<b>PCT</b>	Primary Care Trust
<b>SAP</b>	Single Assessment Process
<b>SCMH</b>	Sainsbury Centre for Mental Health
<b>SFA</b>	Solution Focused Approaches
<b>SHA</b>	Strategic Health Authority
<b>SHO</b>	Senior House Officer
<b>SITREPS</b>	Department of Health Situation Reports
<b>STRW</b>	Support, Time and Recovery Worker
<b>WRAP</b>	Wellness, Recovery and Action Plan

DH INFORMATION READER BOX	
Policy	Estates
HR / Workforce	Performance
Management	IM & T
Planning	Finance
Clinical	Partnership Working
<b>Document Purpose</b>	Best Practice Guidance
<b>ROCR Ref:</b>	<b>Gateway Ref:</b> 7833
<b>Title</b>	A Positive Outlook: A Good Practice Toolkit to improve discharge from inpatient mental health care
<b>Author</b>	CSIP: Acute Programme and Change Agent Team
<b>Publication Date</b>	3rd April 2007
<b>Target Audience</b>	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Directors of Nursing, Directors of Adult SSs, Adult and older people service managers, ward managers, nurse consultants, modern matrons, practice development leads, directors of mental health
<b>Circulation List</b>	Foundation Trust CEs , Voluntary Organisations/NDPBs
<b>Description</b>	This toolkit links acute mental health policy to positive inpatient discharge practice for adults and older people. It should be used to inform the development of improved discharge planning and locally agreed protocols and can assist in achieving reduced lengths of stay on acute inpatient wards.
<b>Cross Ref</b>	N/A
<b>Superseded Does</b>	N/A
<b>Action Required</b>	N/A
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<b>For Recipient's Use</b>	