Next Steps Service Plan

Why have we started?

The service is intended to 'bridge the gap' between inpatient care and community support to facilitate more timely and effective discharges by providing enhanced support for people as they continue their recovery in the community.

It is estimated that on any given day at least 10–20% of all mental health beds are occupied by people who are ready to leave hospital but do not have an agreed discharge package of support to do so. This equates to approximately 1–2 million bed days each year.

Some people remain in beds for excessive periods where clinicians feel they are 'clinically well enough' but do not yet feel comfortable to discharge to their previous level of community care. Some longer stays can result in people's condition deteriorating resulting in the need for more costly long-term care. Crucially, this means people who urgently need admission to beds are sometimes unable to access them.

(NHS England, 2020)

Open Mental Health

mind for better mental health in Somerset

citizens advice South Somerset

SECOND STEP
PUTTING MENTAL HEALTH FIRST

Open Mental Health' is a Somerset alliance of local voluntary organisations and the NHS. We are working in partnership to ensure that residents of Somerset get the support they need, when they need it.

Suicide prevention

Research shows, for example, that between 2005 and 2015 17% of people who completed suicide had recently been discharged from acute hospital services (Tyler et al, 2019)

People in contact with mental health services are at highest risk of suicide in the immediate days and months following discharge2 (200-fold increased risk in the three months post discharge).

Reports of increasing complexity of mental health need, compounded by people losing their usual support networks under COVID19 restrictions, indicate a need for more robust post-discharge support – which has consistently been identified as a priority for suicide prevention. Improving flow through inpatient wards will also ensure that beds are available for timely admission of acutely unwell patients who may be at risk of suicide/harm (NHS England, 2020)

Homelessness

Bed occupancy in mental health services is 93%, well above recognised safe levels. In reality most systems are operating at or above 100% capacity as they are having to send people out of area. This is while a significant proportion of patients in inpatient wards no longer require hospital care but cannot be discharged because support is insufficient to enable them to continue their recovery at home or in another setting (NHS England, 2021)

Reducing length of admission and repeat admissions

Discharges requiring referral to accommodation or rehabilitation led to longer stays. The most significant factors that influenced length of stay were higher observation levels, diagnosis of psychotic illness or bipolar, and discharge to rehabilitation placement. Discharge planning, specifically around referral to accommodation and rehabilitation, was a significant delaying step, prolonging inpatient admission (Crosley & Sweeny, 2020).

What Next Steps aim to do

- Help individuals to spot possible relapse signs
- Establish recovery goals
- Signpost who to contact where to go in a crisis
- Support with managing budgeting and benefits handling personal budgets
- Make opportunities for educational, work-related and social activities
- Work alongside clinical details of treatment and support plan
- Support group work including health promotion and information
- Help to secure and maintain housing

Peer support

Peer workers

WATCH workers will provide an opportunity for social support: self-help, early warning signs and coping strategies independent living skills making choices and setting goals

Recovery College

Recovery College – Peer delivered groups will continue for up to 12 weeks be delivered in groups of up to 12 members
(Nice recommended peer interventions. 2021, p8)

Follow up support from clinical teams

NICE guidelines recommend for clinical teams:

Within 24 hours, a discharge letter is emailed to the person's GP.
A copy should be given to the person and, if appropriate, the community team and other specialist services.

Within 24 hours, a copy of the person's latest care plan is sent to everyone involved in their care.

Within a week, a discharge summary is sent to the GP and others involved in developing the care plan, subject to the person's agreement. This should include information about why the person was admitted and how their condition has changed during the hospital stay (Nice 2021, p8).

When and how Next Steps will offer support

While in hospital – First week of being in hospital

Introduction to a Citizens Advice worker offered and/or taken – we will work with the person to see if they would like support with managing debt, benefits and applications.

Introduction to the Community Navigator and Peer Worker – We will arrange a meeting in the hospital to introduce ourselves and get to know the person. We can support with links to education and work, help to secure a safe place to live and provide some emotional support to build connections and relationships if wanted. Community Navigators can work alongside those we support in hospital and then after they leave for up to 3 months (roughly). Peer worker can continue this for a longer time if both agree.

While in hospital – When a date has been decided for moving on from

A review of any of the barriers to leaving hospital we have worked on together and see what we have been able to do and if there is anything else that needs to happen before transitioning back to the community. This will be done with the Community Navigator and or Peer Worker.

There will be further meeting(s) with Community Navigators and peer worker – Citizens Advice (if needed).

48 hours before leaving the hospital

Your Community Navigator will visit the ward or phone them to see if everything is on track to the person leaving the hospital, and if there is anything we can help with alongside the staff on the ward.

24 hours before leaving hospital

The person will be offered a support call/ video call with their Community Navigator/Peer worker to see how they are and to schedule your first face to face time after leaving hospital.

24hrs 48 hours & 72 hours hours post discharge

The person will be offered 3 face to face support or a video/phone calls (a mix of these if preferred). – If these periods are over weekends or bank holidays support will be offered by the Community Front Room crisis services across Somerset or Mindline Somerset, Details can found on our next steps info leaflet and the Community Navigator/Peer can give these details if needed at any time.

Roughly 3 months

After we have been alongside each other for 3 months support from community navigators will be continued by peer support workers if ok for both parties, and we can make introductions to other services if needed during this time or at any point of our time together

Ongoing

Your peer support worker may continue to see you if this works for both of you and if you would like.

Evidence based models of working

Critical Time Interventions – Directly applied by Next Steps

Research

The prevalence of homelessness among participants receiving CTI was ~five times lower than among those receiving usual care. (Herman et al 2011) CTI was also associated with a significantly reduced risk of rehospitalisation. (Tomita et al 2012) CTI in the Transition from Hospital to Community, 2001-2007 CTI in the Transition from Hospital to Community, 2001-2007,Following on the encouraging results of the first trial with men discharged from the shelter, this second randomized trial tested CTI with 150 previously homeless adults with serious mental illness following discharge from two psychiatric hospitals (NIMH, 2021).

Phase 1 – Month 1

A CTI worker engaging and providing extensive individualised support for participants following discharge from the transitional residence, focusing on areas critical for successful community adjustment. An important objective of the first phase was for the CTI worker to identify, assess, and strengthen both formal (e.g. service providers) and informal (e.g. family and friends) community support networks to ensure that they would endure well after the intervention ended.

Phase 2 – Month 2

The CTI worker continued to provide direct assistance to participants and members of their support network, but the responsibility for long-term support was gradually transitioned to community sources in a planned way. During this phase, participants and members of their support networks were encouraged to address issues on their own, having access to the CTI worker when crises arose.

Phase 3 – Month 3

Entailed formally terminating the intervention and transferring responsibility to the community resources for their long-term sustainable support.

Transitional relationship model – Our broader way of working

Homelessness and reduced admission rates

Links with the council & Housing First training

Psychoeducational

Clinical teams

Social connection

Peer workers, groups – Recovery College, Education & work introductions.

Partnership working

Working alongside wards, citizens advice, clinical, ward and HTT staff

NHS England standard KPI's on discharge planning service

Reduction in length of stay in mental health wards (MHSDS)

Reduction in 6 and 12-hour waits for mental health patients in A&E (from attendance to departure) (ECDS)

Reduction in inappropriate adult acute mental health out of area placements (NHS Digital)

Intensive Transitions Team Qualitative Data Recording

Measured by us

- When the First Contact was received
- When it was delegated to a staff member
- When the first contact was made with the person we hope to work alongside
- Ward admitted to
- Admission status
- Type of interaction and each interaction – Face to face, phone, video call, text.
- Services signposted to
- Peer worker involvement

Measured with clinical input

- Re admission avoided post 3 months to discharge
- Length of inpatient admission while working with Next Steps measured against prior admission length
- Suicide safety planning in place alongside clinical teams – joint working with risk

Intensive Transitions Team Quantitative Data Recording

Where would you have gone to if you needed support instead of Next Steps?

What do you think may have happened if you hadn't worked alongside us?

References

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