MH Discharge Challenge: 10 discharge initiatives

1. Identify the purpose of the admission, set an expected date of discharge (estimated discharge date (EDD)) for when this purpose will be achieved, and communicate this with the person, family/carers and any teams involved in the person's care post-discharge, e.g. community mental health team (CMHT) or crisis resolution home treatment team (CRHTT).

2. Complete care formulation and care planning at the earliest opportunity with the person, and within a maximum of 72 hours of admission.

3. Identify any potential barriers to discharge early on in admission and take action to address these. Where appropriate action cannot be taken, escalate this to the ICB Discharge Lead

4. Conduct daily reviews, such as the 'Red to Green' approach, to ensure each day is adding therapeutic benefit for the person and is in line with the purpose of admission.

5. Hold Multi Agency Discharge Events (MADE) with key partners on a regular basis, to review complex cases

MH Discharge Challenge: 10 discharge initiatives continued…

6. Ensure partnership working and early engagement with the person, family/carers and teams involved in the person's post-discharge support; agree a joint action plan with key responsibilities, for example for social care, housing, primary care, CMHT, CRHTT, etc.

7. Apply 7-day working to enable people who are clinically ready for discharge to be discharged over weekends and bank holidays, and allow people who require admission timely access to local beds

8. Identify common reasons and solutions to people being delayed in hospital once clinically ready for discharge,
e.g., housing support / accommodation.

9. Communicate notice of discharge at least 48 hours prior to the person being discharged, to the person, their family/carers and any ongoing support services

10. Follow up to be carried out with the person by the CMHT or CRHTT at the earliest opportunity and within a maximum of 72 hours of discharge, to ensure the right discharge support is in place