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NHS England

To:
- ICB chief executives
- All NHS Acute, Mental Health and Community Foundation Trust and Trust Chief executives

cc.
- CEs of local authorities
- Directors of adult social services
- NHS England regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

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Dear Colleagues

Discharge Challenge for Mental Health and Community Services providers

As we enter what is expected to be a very busy winter period, we would like to take an opportunity to thank you and your staff for everything you have done and continue to do to ensure that people receive high quality care that best meets their needs in the most appropriate environment for them.

We want to highlight in particular the activity and energy you have put into tackling hospital related discharge delays in the acute hospital setting. The work that has been undertaken and continues to be undertaken, is delivering tangible results with a reduction in the number of discharge delays within hospitals' control of at least 20%. Thank you for this.

With this improvement in mind we now ask you to build on this within community and mental health settings. The National Health and Social Care Discharge Taskforce has asked that integrated care boards and providers of mental health and community inpatient services focus on ensuring that they have robust discharge processes in place, ensuring that patients who no longer need to be in an inpatient setting are discharged and cared for in more appropriate settings.

Based on good practice and evidence, a set of key interventions have been co-developed with a range of system-wide experts to help drive improvements in flow and reduce delayed discharge for mental health and community providers (outlined in Appendix 1).

Discharge Challenge Approach

We know that many organisations already have some of these initiatives in place, therefore we are asking all systems through this challenge, and with our support, to focus their improvement resources on those initiatives that will drive the biggest improvements locally by the end of March 2023.

To deliver against the initiatives there will be a need for engagement across systems with key leaders from the NHS, local government and other relevant local partners, with support from regional executive discharge leads and their teams.

A number of the initiatives are directly within the control of NHS and NHS-funded provider organisations, and as such, we are requesting that all system and provider leadership teams ensure there is focused executive and clinical leadership. There should also be consistent and appropriate oversight of discharge performance from trust boards and ICBs. Partnership working will be key to drive improvements in areas that are not directly within the control of NHS organisations, to ensure clear and timely discharge pathways are in place.

DHSC has recently made £500 million available to support adult social care and discharges from inpatient settings, and mental health and community services are both within scope of this funding. We need you to engage directly with how this money, which will be routed through your Better Care Fund, will be used for the patients in your area; ensuring that the solutions to enable discharge for those patients who require ongoing support are rapidly put in place. It will be paramount that you as leaders can account for how this money will be used and can demonstrate the value that the funding has brought to lowering the number of patients awaiting discharge and the subsequent improved flow through the system.

By the end of the challenge in March 2023, we expect systems to have:

- infrastructure in place to focus on the ongoing implementation of the initiatives
- more local accountability of community and mental health discharges at system/place level to ensure the same level of focus and importance is upheld, and provide parity with acute discharges
- a full understanding of the interventions and the support offer available from NHS England to assist with implementation.

We want systems to be able to evidence demonstrable improvements in discharge related metrics, including:

- avoidable length of stay
- the proportion of beds occupied by someone Clinically Ready for Discharge
- improved flow and timely access to local beds for people who require inpatient admission.

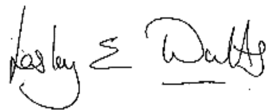
Next steps

A dedicated national NHS England team will work with each regional executive discharge lead to launch the challenge with systems and ensure there is a focus on improving processes and performance around discharge and working across the wider system.

In the meantime, please do begin to discuss as a system your current application of the initiatives, and identify named ICB, Local Authority and provider leads for the challenge, and governance and reporting mechanisms, to help drive implementation between now and the end of March 2023.

We would like to thank you and your teams for your continued hard work improving discharge through the health and care system and ultimately improving patient outcomes by ensuring patients receive the care best suited to them, in the right setting.

Yours sincerely,



Lesley Watts
SRO for Discharge
NHS England

Claire Murdoch
National Director for Mental Health
NHS England

Dr Amanda Doyle
National Director for Primary Care and Community Services
NHS England

Appendix 1

Mental health discharge initiatives

These 10 interventions for mental health need to be seen and set within the context of the whole pathway and to link in with Urgent and Emergency Care pathways and community mental health pathways. Please go to the UEC pathway pressures dashboard to help monitor metrics such as length of stay, and assess the impact that the following interventions are having on flow.

1. Identify the purpose of the admission, set an expected date of discharge (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.

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, e.g. housing support/accommodation. Start by reviewing:

    - Those who are clinically ready for discharge but occupying beds.

    - Adults and older adults with a long length of stay (over 60/90 days for adult/older adult admissions).

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.

Community discharge initiatives

1. Establish board level reporting and executive Senior Responsible Officer (SRO) level ownership with delegated responsibility of the discharge process at organisational and system level.

2. Streamline and align the referral process through a transfer of care hub (TOCH) that is aligned across all partners.

3. Identify people with complex discharge needs at admission and seek the engagement of the person, family, carers and Multidisciplinary Team (MDT) within 24 hours of their admission.

4. Create a rehabilitation plan within 24 hours of admission for everyone admitted to community rehabilitation bedded care and ensure it is reviewed and acted on.

5. Identify bedded capacity requirements by using a discharge pathway capacity and demand tool.

6. Plan workforce to enable people to be admitted and discharged evenly across seven days a week.

7. Ensure that all providers of NHS community beds are onboarded to the Community Discharge Situation Report (SITREP) and that discharge pathway 2 beds have equitable access to pathway 1 resources for discharge improvement.

8. Fully implement Community Criteria Led Discharge (CLD) and Criteria to Reside (CtR) processes across all beds in community hospitals.

9. Move the majority of discharges to earlier in the day – ensuring patients have the wrap around support needed.

10. Use Personal health budgets (PHBs) and discharge grants or Voluntary Care Sector (VCS) support to facilitate early discharge.