GIG CYMRU NHS WALES
Perfformiad a Gwella
Performance and Improvement

Safe Discharge Standards for Wales

NHS Wales Performance and Improvement

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Acknowledgments

We wish to thank the following people for their contributions:

Members of the Safe Discharge Workstream, as part of the National Mental Health Patient Safety Programme and the Discharge Standards Expert Reference Group for their commitment and hard work in drafting and refining the standards.

Staff working in mental health services, local authorities, and partner organisations, including third sector organisations across Wales for their feedback and comments throughout the development process.

Most importantly we wish to thank the people with lived and caring experience who have shaped this work from the beginning to ensure a safer approach to discharge from hospital in Wales.

Introduction

Why the standards were developed

Discharge from mental health inpatient care back home is identified as a period of potential high stress for a person and those around them. The transition can be complex and often involves more than one agency and setting. The **Safe Discharge Standards for Wales** were developed to help improve the consistency and safety of this transition and set out guidance around expected level of care delivery before, during and following discharge from hospital. These standards supplement and build upon the expectations set out in the Mental Health Act Code of Practice for Wales 2016, the Code of Practice for Parts 2 and 3 of the Measure and reflect more recent recommendations for safer discharge. They are also set in the broader context of providing, safe, timely, effective, efficient, equitable and person-centred care and associated legislative requirements and policy.

Wales has a diverse range of people and cultures. In designing services to meet the needs of the whole population, health board planners are required to adhere to the Equality Act (2010) which specifies the protected characteristics as; age, race, gender reassignment, disability (defined to include a "mental impairment that has a substantial and long-term negative effect"), marriage and civil partnership, pregnancy and maternity, religion and belief, sex and sexual orientation.

Welsh Language

Receiving care through the medium of Welsh is a right, not an option, and is considered a crucial part of providing person-centred care. Under the Welsh Language (Wales) Measure 2011, the Welsh language standards ensure that the Welsh language is not treated less favourably than the English language in Wales.

More Than Just Words is the Welsh Government's strategic framework for promoting Welsh language and culture in health and social care. The vision for More Than Just Words is for Welsh to belong and be embedded in health and social care services across Wales so that individuals receive care that meets their language needs without having to ask for it, leading to better outcomes. At the heart of More Than Just Words is the principle of the Active Offer, which places a responsibility on health and social care providers to offer services in Welsh, rather than on the patient or service user to have to request them.

The standards take a pathway approach, following a person's journey from admission, preparation for discharge, to transition and arrangements for follow up. The standards focus on supporting **safer** discharge from hospital, improving the experience and safety of people receiving care whilst guiding staff to support safer transitions, minimising risk and promoting a collaborative, needs led and transparent approach to care.

What are the standards?

Continuity of care is essential as people transition between inpatient and community settings. A person-centred and compassionate approach is needed with clear planning, co-ordination and information sharing.

The standards are arranged as a set of 10 sub-headings to guide practice, under which 17 standards are identified.

In addition to this document, a focus on standardising 72-hour follow-up arrangements in Wales have led to an expansion of standards 16 and 17. Guidance on the clinical element of these contacts can be found in a separate document. All standards included here are the minimum standard expected to ensure **safer discharge from hospital**.

Who the standards are for?

The standards are written for anyone leaving mental health inpatient hospital care, their support networks and staff delivering and supporting care. The standards:

- Apply to anyone aged 18 and over admitted to an adult or older adult acute ward in Wales who is being discharged to a community setting.
- Set out what people using services, their families and carers can expect discharge to look like and how this should be delivered.
- Provide services with an opportunity to identify areas for service improvement that will lead to safer discharge from hospital.

The standards have not been developed for Child and Adolescent Mental Health Services (CAMHS), rehabilitation or dementia wards. Low and medium secure in-patient care will usually have specific guidance relating to discharge in line with Part 3 of the Mental Health Act and associated Code of Practice. Where this does not apply due regards should be given to these standards

Developing the standards

The standards were developed through an engagement and consultation process with staff working across Wales, partner organisations, people with lived experience and their support networks. This feedback has been collated and reviewed alongside evidence relating to effective clinical practice and relevant guidance documents to ensure feasibility in practice and responsiveness to people's needs and views.

The standards have been refined by an expert reference group established specifically to develop these standards. The Safe Discharge workstream led on this work and sits within the National Mental Health Patient Safety Programme which launched in 2024 to focus on improving the quality and safety of inpatient care and experience in Wales.

The Mental Health Patient Safety Programme is part of the NHS Wales Performance and Improvement Strategic Programme for Mental Health (SPMH). SPMH provides system leadership and works to improve safety and outcomes. More information can be found at Strategic Programme for Mental Health - NHS Wales Performance and Improvement

This is the first version of the standards (2025).

Who is responsible and how will the standards be reviewed?

The Safe Discharge Standards for Wales have been developed collaboratively and the responsibility for their delivery and review is shared.

NHS Wales Performance and Improvement is responsible for the publication and review of the standards.

Health boards are responsible for the implementation and internal monitoring of the standards.

Care co-ordinators and staff in hospital and community teams are responsible for delivering the discharge standards, ensuring that people receive care that optimises safety when a person transitions from mental health inpatient care.

Health boards should note that it is anticipated that Healthcare Inspectorate Wales will include adherence to these standards within their inspection framework, and it is critical that health boards not only implement the standards but also be able to provide evidence of how this has taken place. Furthermore, health boards must include adherence to these standards within their own

internal control processes and apply quality improvement techniques to improve from their baseline position.

Terms used

The standards use plain language and intentionally avoid clinical jargon to ensure clarity and accessibility. Terms with specific meanings or relate to policy are explained in the glossary at the end of this document. These terms appear in italics throughout the text to indicate that a definition is provided.

For the purpose of this document, key terms used throughout are:

- 'The person' or 'people' – People who use services
- 'Identified support network' – Friends, families, carers and significant others
- 'The team' – Registered and non-registered staff members identified to deliver care and support during a person's admission. It will also include relevant staff (statutory and non-statutory) viewed as having responsibility for elements of the person's care or engaged in supporting a person in the community after discharge.

The Standards

Expectations around admission and link to planning for discharge (Standards 1-2)

1 Discharge planning commences at point of admission

i. The purpose of admission is agreed with the person where possible and clearly documented in the person's record. Where this has not occurred, the reason why not is documented. The person's care plan, including *Care and Treatment plan* (CTP) must reflect admission objectives.
ii. A ward staff member is named as *discharge co-ordinator* for each person; the name of this role may vary but the duties shall maintain a focus on achieving continuity of care.
iii. Where a *care co-ordinator* has been appointed, they maintain contact with the person and the ward-based team throughout admission and contribute to discharge conversations. They work collaboratively with the discharge

co-ordinator to ensure the person's needs and preferences are met and discharge is as safe as possible.

iv. There is early identification of a person's support network and who will be involved in care planning, clarifying any issues around consent to share information. This is documented in the person's record.

v. Anticipated discharge / transfer dates and destination of discharge are identified with the individual, their Nearest relative/Nominated person and identified support network at the earliest opportunity, i.e. no later than 72 hours after admission, communicated with the person and shared with the person's Nearest relative/Nominated person and support network. This is continuously reviewed by the team in collaboration with the person and their identified support network.

vi. Thorough information gathering (including from the identified support network) at point of admission informs planning and contributes to well supported, timely discharge.

vii. Processes are in place to identify people who may be at risk of delayed discharge with barriers identified as soon as possible and specific planning initiated to address these, for example social care or housing needs. This includes consideration of functional/cognitive assessments to establish issues that could impact on achieving a smooth discharge home such as identifying an appropriate destination of discharge (see also 4, 8).

viii. Where a person is homeless, or at risk of becoming homeless (including rough sleeping or those living in insecure housing) (see also 3, 14), or the person has a co-occurring mental health and drug or alcohol misuse issues, relevant specialist services are engaged at admission to support planning (see also 3).

ix. Where a person has been assessed as lacking capacity in respect of an aspect of their care and treatment, their wishes and feelings are always considered and documented in accordance with the principles set out in the *Mental Capacity Act 2005*.

x. Funding mechanisms for discharge are agreed early to achieve the best outcomes for the person and align with existing statutory duties.

xi. Discharge planning conversations result in an initial formal written discharge plan within 7 days of admission.

xii. People who are eligible for *Section 117* aftercare under the *Mental Health Act* are identified on admission and relevant teams/bodies are notified (see also 11).

2 Expectations around admission and discharge are based upon collaboration between the person, their identified support network and team

i. As soon as discharge planning begins, the person is asked how they would like to be involved in discharge conversations and who, if anyone, they wish to support them with this. Preference is reviewed over time, as this may change. People also have the statutory right to support from an Independent Mental Health Advocate (IMHA).

ii. If a person does not wish to be involved in discharge planning, staff should seek to understand the reason for this and whether they would still want to be involved in some aspects of their discharge planning. The person is given opportunities to update their preferences over time.
iii. Where a person does not wish to be involved or does not have the capacity to fully engage, staff must ensure their views are represented as much as possible. This may involve consulting their identified support network or other *advocates*. Clear documentation is maintained to ensure the person's wishes are visible to all involved in their care.
iv. Conversations take place to explore what the person needs to feel safe, what this looks like and how the person will communicate when this is or is not being achieved. This is documented and communicated to all involved in the person's care.
v. The person and their team develop a shared understanding on how they and their team will recognise when the person is ready to be discharged. The purpose of admission is regularly reviewed throughout the inpatient stay with the person and their identified support network.
vi. People have access to *culturally appropriate* IMHAs to discuss their views and expectations about admission and discharge. This is a formal offer with the outcome recorded in person's record (see also 5).

Collaborative discharge plans (Standards 3-7)

3 Discharge planning is collaborative and agreed by all involved

i. Each person admitted to hospital is regarded as a partner in their own care and discharge planning. Choice and autonomy are respected and promoted.
ii. All staff are introduced to the person and their identified support network, no one is a stranger. To support this photo boards are visible on the ward and all staff wear identification badges. Welsh speaking staff are clearly identifiable.
iii. Planning is multidisciplinary, comprising of ward staff, community staff, GP and relevant local authority and third sector organisations working together to develop plans in collaboration with the person and their identified support network.
iv. The team engage early with any external services that will play a key role in the person's ongoing care following discharge from hospital.
v. Regular planning meetings discuss progress toward transition from hospital. This may be held as part of routine *multidisciplinary team* (MDT) meetings or established separately.
vi. Planning meetings review discharge dates and monitor membership to ensure relevant attendance. Engagement with specialist teams and organisations are enlisted to ensure meetings remain needs led, and outcomes focused.

vii. If a named professional is unable to attend and rescheduling the meeting is not possible, an alternative named professional is designated to attend in their place and assumes responsibility for any actions assigned.
viii. Roles and responsibilities of individuals involved in the discharge planning process are agreed and documented. An explanation is given to the person and their identified support work to ensure clarity around the need for each individual to be present.
ix. Professionals and members of a person's identified support network named in the plan are aware and agree to contribute and lead as required (see also 12).
x. Where a person will require ongoing secondary care and intervention on discharge, a care co-ordinator is allocated "as soon as is reasonably practicable" after admission as per the *Mental Health (Wales) Measure*. Initial introductions are made as soon as appropriate in cases where the person is not already known to community services.
xi. Any safeguarding concerns/needs are identified as early as possible; these may relate to the person and/or their identified support network. The team consult with *safeguarding* teams and others as appropriate, e.g. Police, Children's Services, Health Visitor, community organisations such as Women's Aid etc.
xii. Where a person is homeless, or at risk of becoming homeless (including rough sleeping or those living in insecure housing), relevant homelessness services are consulted and engaged during the discharge planning process and post-discharge support plans as appropriate (see also 14).
xiii. Where a person has a co-occurring mental health and drug or alcohol misuse issue, the local drug and alcohol treatment teams (or relevant third sector agency) contribute to the discharge planning process and post-discharge support plans as appropriate.

4 Discharge plans are person centred and focus on strengths and needs

i. Discharge plans are written collaboratively using the person's own words. If this is not possible, the reason is documented, but this is revisited throughout admission and the discharge planning process.
ii. Discharge plans consider all care and support needs including psychological, physical health, pharmacological, social, cultural, spiritual/faith, occupational, housing and financial needs, environmental, sensory needs, cognitive functioning and communication needs and preferences.
iii. Discharge plans support *culturally appropriate care*.
iv. Discharge plans are tailored to supporting individual recovery and utilise a strength-based approach. Plans are needs led, outcome focused and capture realistic personal goals.
v. Discharge plans capture 'what matters to me' informed by conversations identifying community-based activities for people to engage with that build social connections and support personal recovery and wellbeing.
vi. Discharge plans anticipate barriers to smooth discharge (see also 8).

vii. Discharge plans identify support needs, level of independence and considerations for adjustment to community life (see also 15). Change in levels of support required following discharge are monitored and plans adapted.

viii. Discharge plans anticipate opportunities for the person to spend time at home and in the community. There is consideration of potential barriers to facilitating this (see also 8).

ix. *Person Reported Outcome Measures, Person Reported Experience Measures* and, as appropriate, C*linical Outcome Measures* are collected at admission, reviewed throughout inpatient stay and re-administered at discharge to support monitoring and progress toward personal goals. Welsh language and easy read versions are available and offered to each person.

5 The person influences and shapes the plan for their own discharge, in a format that is accessible to them

i. A person's literacy and communication needs and preferences, including language are noted on admission. All written information is provided in an accessible format, including easy read versions, and compliant with *Welsh Language Standards*.

ii. *Reasonable adjustments* are a legal requirement under the *Equality Act 2010* to ensure services are accessible to disabled people and should be put in place where needed, including support around discharge planning (reasonable adjustments apply to physical, cognitive and communication needs).

iii. People have access to *advocacy* to support with discharge planning and articulating their views and wishes, *reasonable adjustments* are made to ensure the person is able to take up the offer of advocacy.

iv. The principles of the *Mental Capacity Act* (MCA) 2005 are applied to support people with decision making. The MCA 2005 applies to those age 16 and over.

v. Safe spaces are created for people to discuss options around their discharge. Safety is experienced in terms of protecting physical, relational, emotional, spiritual and cultural safety. This will look different to different people.

vi. Staff are committed to collaboration and the fundamental right for people to be involved in planning their own care and discharge.

vii. Where a person is looking to self-discharge against medical advice, local ward policy should be followed. Immediate plans to ensure discharge is as a safe as possible should be undertaken and fully communicated to all involved in the person's care, including the person's identified support network.

6 Each person and their identified support network have access to a range of flexible resources to support them plan and prepare for the transition out of hospital

i. Everyone has access to *recovery college* sessions or similar education and skills courses to help prepare for the transition from hospital to home.
ii. Activities offered through admission support maintenance, development or regaining of skills and knowledge that will support adjustment following discharge, this may be in relation to managing finances, self-care, and medication management. Activities are adapted to suit individual need, interest and consider digital inclusion.

7 The person's identified support network (with consent) is actively involved in discharge planning

i. A person's identified support network is identified by that person and recognised as a key mechanism in supporting discharge planning and adjustment to leaving hospital.
ii. A person's identified support network is involved in planning for discharge as early as possible, asked how they would like to be involved and about any support they may need to participate.
iii. A person's identified support network is aware of who to speak to and how should they wish to make contact. Time and safe spaces are provided to enable feedback, raising of questions and concerns.
iv. A person's identified support network has access to *advocacy* and are informed of their rights under the *Mental Health Act*, where appropriate.
v. *Reasonable adjustments* are put in place to support any member of a person's identified support network who have communication needs.
vi. Routine conversations are undertaken to determine whether a *carer's assessment* is required for any unpaid carer, the offer and outcome are documented in the person's notes (*Social Services and Wellbeing Act, 2014*).

Use of time away from the ward to support planning, anticipating early discharge and barriers to discharge (Standard 8)

8 Use of time away from the ward (Section 17 leave or otherwise, accompanied or unaccompanied) is agreed through collaborative discussion and planning around purpose and safety

i. Where it has been agreed for a person to spend time away from the ward, staff check that the person has reliable and accessible means to contact the ward should they need to, for example access to money, access to a phone, the correct contact details for the ward. The person and their identified support network know what to do should they require assistance during the leave period.
ii. In preparation for time away from the ward, risk formulations and *Person-Centred Safety Plans* (PCSP) are reviewed with the person. PCSPs ensure the person knows how to keep themselves safe, and this is shared with the persons named within it, including members of the person's identified support network.
iii. Prior to leave, there is discussion between the person, their identified support network and the team to consider how time away from the ward could be used, the rationale and opportunities that may be therapeutically beneficial to support recovery. This may include interventions that support occupational therapy assessment.
iv. Time away from the ward is reviewed in collaboration with the person and their identified support network on return to the ward to inform and support discharge planning.
v. Where a person is detained under the *Mental Health Act*, conditions for taking *Section 17* leave are clearly communicated to the person and identified support network supporting leave (a copy of the form is provided). Where relevant, community services are involved in discussions around planned leave and any conditions attached.

Confirmation of discharge date (Standard 9)

9 Discharge dates and times are agreed in advance

i. The person, their identified support network and team agree the discharge date. Discharge should be a planned event with the person, their identified support network and any community support services fully aware of the rationale and onward plans.
ii. Where purpose of admission is achieved early, a *multidisciplinary team* (MDT) discussion is undertaken to determine and agree arrangements for discharge to be expedited. Plans are updated to reflect the change and the person's identified support network are consulted.
iii. Arrangements for discharge are confirmed with the patient's identified support network and time to discuss any concerns or queries is provided.
iv. Arrangements for follow up within 72 hours are confirmed and documented prior to the person leaving the ward (see also 16).
v. Travel arrangements to accommodation upon discharge are confirmed in advance, this may involve the identified support network assisting with travel where possible. Alternatively, the team should ensure the person has access to a telephone, bus timetables, apps and support to plan accordingly.

vi. A discharge pack is compiled and individualised for each person (see also 10).
vii. If an individualised support plan and follow up is not in place, discharge does not proceed.
viii. The day of discharge is planned to maximise the opportunity for the person's identified support network and team to support and respond at the point of discharge.

Provision of information and care plans (Standards 10-11)

10 Discharge packs are provided to everyone

Discharge packs include:

- Care and Treatment Plans and Person-Centred Safety Plans (see also 11)
- Directory of local support, including drop-in centres, pharmacies, food banks, community groups, voluntary organisations, peer service
- Names and numbers of relevant local statutory support services, who to contact and when, including out of hours services.

Discharge packs are shared in a way that is accessible to the person (including easy read if appropriate) and should reflect the information provided via discharge planning courses.

11 Prior to discharge, Person-Centred Safety Plans (PCSP) and Care and Treatment Plans (CTP) are updated in collaboration with the person and their identified support network

i. Each person is supported and encouraged to define their own needs in a way that is accessible to them.
ii. *Care and Treatment Plans* (CTP) are reviewed with the person and identified support network prior to discharge, with reference to *Section 117* aftercare if appropriate.
iii. Where a person has a *Person-Centred Safety Plan* (PCSP), these are reviewed in preparation for discharge. Where a written PCSP is developed, this remains with the person and a copy shared to their identified support network and relevant professionals.
iv. The risk, formulation and *crisis and contingency plan* is reviewed and confirmed with the person and their identified support network. The person has a copy, and this is shared with relevant professionals.
v. People have access to support from IMHA services to discuss, review and raise any questions around their Care and Treatment Plans (CTP) and Person-Centred Safety Plans (PCSP).

Multiagency communication (Standard 12)

12 Discharge is communicated across agencies on day of discharge

i. Relevant professionals involved in supporting a person's ongoing care are advised of the discharge arrangements in advance and again at point of discharge. This includes the address and contact information (including telephone numbers) for the person.
ii. Everyone identified in the discharge planning process as involved in ongoing care is sent a copy of the agreed plan for follow up, ongoing community care arrangements, *Care and Treatment Plan* (CTP), crisis and contingency plans and medication monitoring arrangements within 24 hours of discharge.
iii. The person has a copy of their *discharge summary* upon discharge, which is copied to the GP within 24 hours of discharge, to include reason for admission and how the person's condition has changed, diagnosis, medication, and ongoing community care arrangements.
iv. Where a person has received for a specific assessment during admission, the outcome is shared with the person and with their consent, relevant professionals involved in onward care. Where a referral for assessment has been made but not yet completed, timescales and next steps for communication are provided to the person and relevant professionals.

Medication (Standard 13)

13 Follow up arrangements for managing medication and acquiring medication prescriptions are confirmed in advance of a person leaving the ward

i. In preparation for discharge people have access to pharmacy consultation to discuss their medication and to understand how to obtain their next prescription.
ii. Where a person falls within the *Equalities Act framework*, they are advised/supported to receive a community pharmacy assessment to support *reasonable adjustments* in relation to medicines management. For example, large print labels, non-click bottle tops, reminder charts.
iii. People have all the necessary information around reason a medication is prescribed, dosage, route, timings, side effects, where to get their next prescription from, risks in stopping medication and relapse, and storage.
iv. Communication is tailored to meet individual needs, written information, apps and visual imagery is used as appropriate to confirm understanding.

Support is given to people who require use of an alarm and/or boxes to manage medication.

v. At point of discharge, the person and their identified support network are provided with a patient copy of the discharge medication list and a community pharmacy copy of the discharge medication list (if not sent electronically) to trigger the community pharmacy to undertake the Discharge Medication Use Review service.

vi. People are provided with up to 2 weeks of take-home medication /prescription on discharge. Where this presents as a risk, this will be adequately assessed and mitigated on an individual basis and the duration of the medication supply reduced accordingly. The team confirm and respond as necessary to any medication supplies already at home and if this has changed since admission.

vii. Where a person is discharged to the care of another person or agency, there is a discussion with that person/agency around medication management. Risks are clearly outlined and contingency plans documented and shared. The 2 weeks of take-home medication /prescription may be negotiated on an individual basis where a person is discharged to a staffed placement setting.

viii. The team confirm the person's understanding around how to access prescriptions for further medication and who to contact with any concerns following discharge.

Appropriate destination of discharge (Standard 14)

14 Discharge destination is deemed appropriate to meet a person's needs and wishes and will continue to support recovery and wellbeing

i. Where concerns are raised around appropriateness of accommodation, consideration is given to appropriate multidisciplinary team involvement to understand needs. Where accommodation does not meet a patient's needs, this should prompt discussion around alternatives. This takes place well in advance of the discharge date.

ii. A person has opportunity to voice preference around where they wish to live on discharge from hospital and suitability of identified options.

iii. If a person has capacity to decide their destination of discharge, even if professionals deem it to be unsuitable to their needs, this should be documented. The team can discuss alternatives, but ultimately if the person has capacity to choose then their decision stands.

iv. A person's identified support network is involved in planning where the person will transition to and has opportunity to express views on suitability of options. There is consideration of their role, needs and preference of destination of discharge.

v. Where a person is homeless, there is a multiagency approach to identify suitable accommodation and a mechanism agreed for follow up and support in the community. *NICE guidance* on integrated health and social care for people experiencing homelessness (2022) sets out how to

approach care and support for people experiencing homelessness, including rough sleeping.

vi. Local authority, third sector and community organisations are involved in ensuring a person's needs are supported holistically as appropriate.

vii. Suitability of accommodation is informed by the involvement from multiple agencies to support identification and investigation of any environmental issues such as damp.

viii. The discharge co-ordinator takes responsibility for supporting and co-ordinating concerns relating to suitability of the environment, for example where there may issues around access to electricity, water, money, food. Referrals should be made to appropriate support services and advice agencies, such as Citizen's Advice as required in advance of discharge.

ix. Where a person's preferred destination of discharge may not be possible, support is given to the person to ensure they understand the rationale and there is collaborative exploration around the alternatives available (see also 14).

Supporting adjustment (Standard 15)

15 Opportunities to support transition and adjustment from hospital to home are explored during the discharge planning process

i. Where a person will receive ongoing community care and support following discharge, staff visit prior to discharge to introduce themselves.

ii. Where a person is engaged in psychological work during admission and this work is unfinished at point of discharge, agreements are made around how this work will be maintained within the community. Such as transfer to the community team or if the work initiated by an individual therapist is to continue with that same person. If the latter is decided, this is agreed for a finite period.

iii. Availability of local *peer support* groups, drop-ins, and community groups are identified and introductions made prior to discharge to promote a graded approach to supporting recovery and transition. Information on local, up to date community-based support services are provided based on individual need and interest that is meaningful to the person (see also 10).

iv. Clear advice around navigating the health and care system, in a format that is understandable to them, is provided to each person and their identified support network.

v. A person's identified support network is provided with information, signposting and contact details for raising concerns about a person's wellbeing following discharge and what action they can expect.

vi. There is a focus on promoting access to training and education to promote and maintain wellness, such as recovery colleges, aging well. These are identified in advance of discharge and arrangements for introductions made (see also 6).

vii. Referrals to support services in the community are anticipated and undertaken early, including referrals for physical health and wellbeing interventions. The referring team confirm service capacity to receive the referral.

viii. The person is informed of their rights under the *Mental Health (Wales) Measure*, such as reassessment, and the *Mental Health Act* (in particular, *Section 117* where this applies).

Follow up arrangements (Standards 16-17)

16 Arrangements for 72 hour follow up are confirmed and documented prior to discharge. Method, day, time, place and by whom is agreed

i. Everyone discharged from hospital in Wales has a follow up appointment arranged, to take place within 72 hours of discharge as a ~~(m~~inimum standard. (Locally agreed standard of 48 hours in some areas).

ii. Follow up takes place face to face, in circumstances where this is not possible, a clear rationale is documented.

iii. Consideration is given to the day of discharge and ability of a community service to provide a follow up appointment.

iv. The professional undertaking the follow up appointment is known to the person wherever possible. The venue for follow up, for example the person's home or community team base, is the most suitable option for the person. If these conditions are not possible, the rationale is documented in the person's record.

v. People open to secondary care services, such as a *Community Mental Health Team* (CMHT) are followed up by their named team.

vi. People who are not open to secondary care services are followed up by the *crisis resolution/ home treatment team* or, in exceptional circumstances, ward team dependant on locally agreed approach. The decision over who takes on this role is agreed prior to discharge and is communicated to all involved.

vii. People who receive hospital treatment outside of the area but return to their area of residence receive follow-up by their local team. The discharging out of area ward should contact the local team and ensure post discharge support will be provided by a named person. This is communicated to the person, their identified support network and all involved in the person's care and clearly documented in the notes.

viii. In all cases, documentation is consolidated in a way that prevents people from repeating their story multiple times and to different professionals.

ix. If unable to contact the person post discharge, attempts are made to contact the person's identified support network. The team should refer to the health board's local policies for escalation and guidance as required.

17 Follow up is compassionate, purposeful and provides opportunity for further planning

i. *Person-Centred Safety Plans* (PCSP) are developed and reviewed with the person and their identified support network and used as the basis of conversations at follow up. Where this is a written plan, the person keeps a copy. This is shared with the identified support network and relevant professionals involved in ongoing care. The person is encouraged to share their PCSP with anyone they choose.
ii. Follow up appointments and outcomes are recorded in the person's notes.
iii. Any concerns and risks raised by the person and their identified support network are escalated as needed.
iv. Outcome measures, such as *ReQol*, are completed and inform further planning and discussion around personal priorities and goals for recovery.
v. A review of arrangements for onward referral and any barriers are discussed with the person and their identified support network during the follow up appointment.
vi. Follow up appointments are an opportunity to confirm further plans around care and treatment, understanding of medication, identifying need for signposting or further referral
vii. Further follow up should be offered as appropriate, even if the person is not open to mental health services when discharged from hospital.
viii. *Care and Treatment Plans* (CTP) and *Person-Centred Safety Plans* (PCSP) are updated in collaboration with the person, based on information from the follow up appointment discussion.
ix. Follow up appointments are meaningful for the person, recovery-focused, and take consideration of the capacity, needs and preference of the person's identified support network

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