	Admission i.e 1st 3days	Phase 1 – 7 days	Stabilisation: Day 8 onwards	Recovery / discharge (Week prior to discharge)
Mental Health	Assessment + Initial treatment plan Review by consultant within 2 working days of admission Background Information(PMhx/Meds) to be obtained from GP/CMHT MHA /MCA – referral to advocate, IMHA and IMCA (as appropriate)	1st MDT Review Initial working diagnosis formulated and Treatment Plan Discussion around medication and give patient information (PIL) Development of Keeping healthy, well and connected care plans.	MDT Review Finalise diagnosis and info on diagnosis given to patient. Weekly Senior Psychiatrist Review (Consultant/SAS Dr) Regular reviews of Keeping healthy, well and care plans	Prepare patient for discharge GP Fax to be sent to GP re discharge medication Discharge summary to GP/CMHT completed within 7 days of d/c
Physical Health	Admission assessment (/doctor, nursing and physical health assessment). Bloods/ECG/NEWS Smoking cessation	Liaise with GP re background history Feedback blood results to patient Smoking cessation Encourage patients to attend exercise groups / gym	Encourage patients to attend exercise groups / gym	Send information on physical health / investigations to GP via discharge summary
Safety	Keeping Safe Care Plans Risk formulation on admission Observations level.	Review observations Manage self-harm/harm to others		Crisis plan to done with patient Complete 48 hour post discharge call [1]
Therapeutic Activity	Introduction Establishing rapport	Psychological assessments, OT assessments, as required. Brief therapeutic interventions to promote stabilisation and help successful discharge	Encourage attendance at therapeutic groups	Planning for discharge with patient If planned discharge - Pre-discharge session with member of MDT as appropriate.

[1] Arrangements for a post discharge follow up call (at approximately 48 hours post discharge) for patients who are not being transferred to another NHS hospital and/or do not have a confirmed community mental health team/crisis recovery home team appt within 72 hours of discharge, and private patients who are being transferred back to the care of their GP.

		Psychology to provide a diagrammatic formulation to help reduce risk and levels of observation Encourage attendance at therapeutic groups – 7 day programme Weekly Primary Nurse/Key worker session		Completion of reports to ensure continuity of support/care
Outcomes	**Complete HoNOS on admission** Other outcomes – GAD/BDI/BAI etc. Attendance at Ward Community Meetings	**Complete DIALOG + with patient** Disease specific outcomes – PD / Psychosis etc		Complete Discharge HonOS Discharge DIALOG FFT or Patient survey
Family & Carers		Liaise with family Informant feedback from family	Joint review with carer/family (if patient consents and appropriate)	Joint review with carer/family as part of discharge planning
Community MH Team		Liaise with CCO/Psychiatrist for background information / risk	If no CMHT – request referral via local Trust to identify CCO Psychiatrist	Provide information to HTT/CMHT