Parliamentary and Health Service Ombudsman

Discharge from mental health care:

making it safe and patient-centred

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Content warning

This report includes references to suicide. It discusses cases where people have taken their own lives.

If any of the issues in this report have affected you, the Samaritans can help. You can call them for free on 116 123, email them at jo@samaritans.org or visit www.samaritans.org to find your nearest branch.

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About us

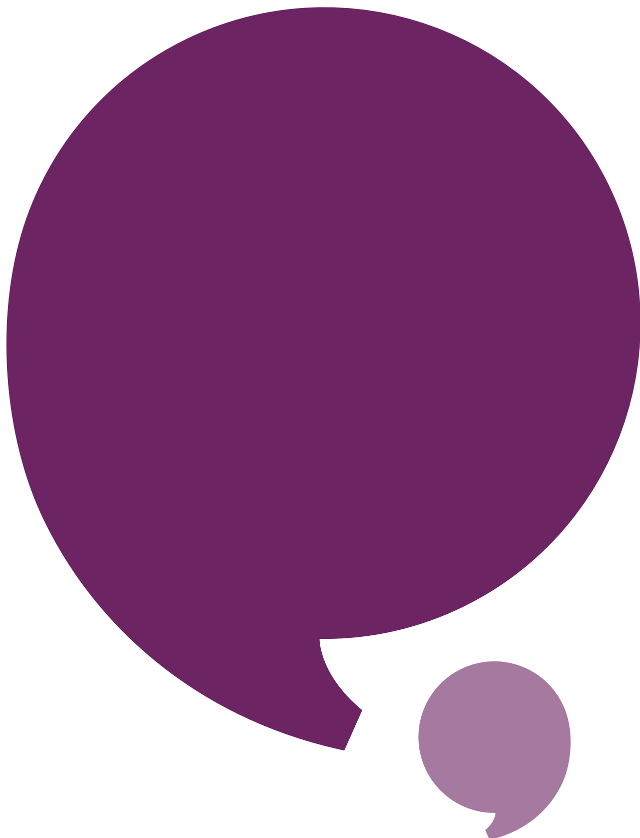
We are the Parliamentary and Health Service Ombudsman. We independently investigate complaints about UK Government departments and the NHS in England.

Our service is completely free, focused on fairness and open to everyone.

We champion higher standards of behaviour to help inspire a better relationship between people and public services.

We work closely with people to understand where, how and why public services sometimes fall short and fail to put people first. And then we find ways to put it right. This can involve explanations, apologies and taking steps to learn and improve.

We believe in the power of complaining to bring lasting change. We share findings from our casework more widely to help improve public services and complaint handling for everyone. This can include presenting reports to Parliament so it can make sure organisations act on our recommendations.



Foreword from the Parliamentary and Health Service Ombudsman

The issue of unsafe discharge from hospital is nothing new. The year before I took up post as the national health Ombudsman, my predecessor had seen patients not being assessed or consulted properly before discharge, carers not being informed and people being kept in hospital due to poor coordination across services.

Any health or social care environment can develop a 'closed culture' where poor working culture or practices risk causing harm to patients and affect a service's ability to respond when things do go wrong. Settings that care for people who may be less able to advocate for themselves, such as inpatient mental health wards, are at even greater risk. During my tenure as Ombudsman, I have repeatedly called for urgent action to address patient safety and cultural issues in mental health services. This has included my demands for a statutory inquiry into the deaths of people being cared for in Essex inpatient settings and the need for a radical transformation of eating disorders services.

When we think about transfers of care between mental health settings, it is clear that decisions are always a balance of considering what is in a person and their carer's best interests, resources and safety. The cases highlighted in this report show what happens when transfers of mental health care go tragically wrong. They demonstrate why collaboration between health and care professionals, families, carers, and individuals is key, and why allowing the time for clear and honest communication around decision-making and care planning is vital. Everyone involved should be guided by the principle of 'progress' over 'process': that we should be thinking about transitions in care as steps on a path to recovery rather than just administrative procedure.

It is right that we recognise and pay tribute to the overwhelming majority of hard-working professionals who are commited to delivering care for those who most need it on a daily basis in spite of huge pressures. The failings we see in my Office's mental health casework are symptomatic of services that have lacked the necessary political prioritisation and real will for radical change. The lack of traction in bringing about reform to the Mental Health Act is a testament to this. It is something the Government must address as a priority if it wants to prove it is committed to making vast improvements for people using mental health services.

Although we have seen valuable steps to change access and attitudes towards mental health conditions and care, reaching the point where mental health is given equal priority to physical health in terms of access and outcomes of care still remains a long way off. But we must remain determined to see radical improvements. We cannot fall victim to the same revolving door of short-term policies and planning of mental health pathways.

Rob Behrens CBE
Parliamentary and Health Service Ombudsman

Introduction

"I once heard a description of a patient journey as being like moving between islands – you were fine if you were on an island (i.e. in a service) but, if you had to move to another island (transition, discharge or referral on) it was like sailing and trying to find a port to have your entry visa checked and get through customs. If it wasn't up to scratch, they wouldn't let you off the boat and you would have to sail back or find another island, or you could get stuck in customs while they checked you in."

Geoff Brennan, Safewards initiative Clinical Supervisor, Kings College London

"The discharge process should be about enabling people to lead their best lives."

Sarah Rae, MINDS NIHR Study Joint Lead Applicant and Mental Health Expert by Experience

The public understanding of the 'bed backlog' is well established around NHS acute hospital and emergency settings. Ambulance queues outside A&E departments give a picture of a disjointed health and social care system, leaving people 'stranded' while waiting for follow-up care and affecting patients elsewhere.

The Care Quality Commission's (CQC) most recent 'State of Care' report points to a similar backlog in mental health services, where gaps in community care provision are putting 'pressure on mental health inpatient services... leading to people being cared for in inappropriate environments – often in emergency departments' (page 6). This is combined with 'an increasing pressure to discharge people from hospital' (page 37).

Headlines typically focus on the crisis in accessing mental health services, long waiting lists and the patchwork of availability of care across the country, all made worse by the COVID-19 pandemic. Public inquiries have looked for answers and radical change in response to the tragic deaths of patients in inpatient mental health settings, which are the very places that should offer safety for those in need.

The Department of Health and Social Care has commissioned a series of national investigations into inpatient care led by the Health Services Safety Investigations Body (HSSIB).

Launched in autumn 2023, these investigations are looking at how providers of inpatient mental health services learn:

- from deaths in their care
- how young people are cared for
- how 'out-of-area' placements are handled
- how to develop a safe, therapeutic staffing model.

It is crucial to acknowledge the immense efforts of the vast majority of the mental health workforce to deliver the very best care possible with patients' needs at its core. To make sure mental health services can properly respond to a surge in demand where one of the biggest challenges is staff recruitment and retention (CQC, page 50), we cannot just look at the front door to services in community and crisis care. We need to give equal attention to how people move on from inpatient and emergency settings back to their homes.

We must not overlook patient safety in the transition from inpatient to community care and beyond. The temptation is to concentrate on speed, with data focused on the number of days from admission to discharge. While shorter stays should be the ambition for patients who are well enough to leave hospital, this cannot come at the cost of patient safety, supported recovery and what is right for the individual, their carers and loved ones.

When we talk about discharge planning and transitions of care, we are talking about how the experience of people leaving hospital, either to their home or to a different community-based service, is managed. Unsafe discharge potentially leads to poorer outcomes for patients and the risk of repeated cycles of readmission: a revolving door in and out of services.

Developing our report

We analysed more than 100 complaints that we investigated between April 2020 to September 2023 where we had found failings in care that involved mental health care. Complaints related to discharge and transitions in care emerged as common themes across these cases. The six cases in this report show where we have found failings specifically around discharge from inpatient mental health services or emergency departments caring for someone with a mental health condition.

The cases represent a broader trend of issues in planning, communication and care, both during and after discharge. These transfers of care offer an insight into people's journey through a fragmented system and are not necessarily unique to mental health. Problems that happen around the point of discharge from inpatient care often reflect wider issues in that system, just as improvements in the working culture and processes around discharge can help improve care across the wider pathway.

As well as analysing the evidence from complaints, we spoke to people with personal experience of discharge from inpatient mental health settings, people working in mental health services, policymakers and representatives from the voluntary sector.

We use this evidence to make recommendations about how good discharge should be carried out and the wider values that guide discharge care. We recognise the immense pressure on the NHS and wider services. We present recommendations that will help avoid the problem of poorly planned discharge which has a negative effect on people, families and resource in the health system.

Transfers in mental health care: a national picture

During 2021 to 2022, data shows that more than 50,000 people were detained under the Mental Health Act (NHS Digital). Nine out of ten adults with mental health conditions are supported in primary care (NHS Long Term Plan, p. 68). Some people need more intensive and specialist inpatient care. In 2021 to 2022, more than 97,000 people in England were admitted into NHS-funded mental health, learning disability or autism inpatient care.

While access to inpatient care is important, so is the timely transfer of care back into an outpatient ('community') setting, when people's mental health improves. This is about a careful balance, weighing up the risk of keeping people in inpatient care too long and discharging people too early. The point at which people leave inpatient care can be high risk for a patient's safety. The transfer to community settings must be managed carefully. It must be 'purposeful, patient-orientated and recovery-focused', as detailed in the NHS Long Term Plan (page 71).

The 2016 National Institute for Health and Care Excellence (NICE) guidelines on the 'transition between inpatient mental health settings and community or care home settings' are clear about the implications of poor transition. They refer to data from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), which shows that recent discharge from hospital continues to be a period of high risk for people dying by suicide. In 2010 to 2020, 14% of all patient deaths by suicide happened within three months of discharge from inpatient care (NCISH Annual Report 2023, page 24). The highest rate of patients dying by suicide in this time was within the first two weeks of leaving hospital.

The right to receive professional and safe standards of care at a time of need is at the heart of the NHS Constitution. And the right to life is protected in UK human rights law. But people deserve far more from our mental health services than being kept alive. They deserve to live well.

People experiencing a mental health crisis often go to emergency departments at hospitals, involving assessment by psychiatric liaison teams followed by admission or discharge back to the community. Data from NHS Digital shows that in 2020 to 2021, there were more than 270,000 attendances at A&E departments in England where a person was recorded as having a primary diagnosis of a psychiatric condition. Although emergency departments are very different environments to inpatient settings, the basic principles of good and safe discharge planning must remain.

When these principles are not supported, it has a human impact and adds pressure to services. When services are overstretched, people may not be able to access the right service for their needs at a particular time. This will have a bearing on what happens when people are discharged from services or when their care is transitioned to a different setting. For example, changes in how police forces will respond to calls related to mental health announced in 2023 under the 'Right Care, Right Person' agreement demonstrate the need for clear understanding of each service's role in responding effectively to a person in crisis.

The cases brought to us show the human cost of mistakes made in discharge planning, both in discharge from inpatient care and following assessment in emergency departments, or when follow-up care falls apart.

So that we do not see the same failings in care happening again, when these mistakes happen, the health service must:

- be open and honest in its response
- acknowledge the impact it has had
- commit to learning.

Complaints about discharge and transitions of care in mental health settings

When something goes wrong in the NHS, patients, families or carers can make a complaint and ask for it to be put right. Individuals must raise their complaint with the organisation involved before bringing it to us.

This is so the organisation has the chance to put it right. We know from the number of complaints we receive, and our own research, that people being cared for in inpatient mental health settings are among those least likely to complain about their care or treatment. The reasons for this are likely to be varied and could include:

- a lack of confidence in how to complain about an NHS mental health trust
- a fear of the repercussions of raising a complaint
- the continuing stigma associated with severe mental health conditions
- the ability to complain while being unwell with a mental health condition.

The complaints landscape for mental health is also complicated, with different types of complaints falling under the responsibility of either ourselves (the Parliamentary and Health Service Ombudsman), the Local Government and Social Care Ombudsman (LGSCO), the CQC or the Mental Health Act Tribunal.

Organisation	Responsibility for mental health complaints
Care Quality Commission (CQC)	Complaints about how powers or duties have been carried out under the Mental Health Act
Local Government and Social Care Ombudsman (LGSCO)	Complaints about the actions of individuals employed by local authorities such as approved mental health professionals
Parliamentary and Health Service Ombudsman (PHSO)	Complaints about care and treatment commissioned or delivered by the NHS in England
Mental Health Act Tribunal	Individuals have a right to apply to the Tribunal to ask if they can be discharged from a section

All of these issues affecting the ability to complain can be made worse by the feeling that mental health inpatient settings are 'closed off', with families and carers not as exposed to the realities of day-to-day life and care on the ward. We must consider whether the complaints process is set up to meet the needs of this group of people. We do not have the power to investigate an issue unless we have received a relevant complaint, even if it is a known problem and in the public interest to do so. The cases in this report are likely to be a small sample of a more widespread issue.

Failings in discharge is an issue we have commented on before. Five years ago, we published our report 'Maintaining momentum: driving improvements in mental health care', which shared case studies of complaints about:

- diagnosis
- failure to treat
- risk assessment
- a lack of dignity and due regard for human rights in mental health care
- inappropriate discharge and aftercare.

We highlighted the huge difference between the NHS ambitions of the time (as set out in the 'Five Year Forward View for Mental Health') and the reality of the real-world discharge process. Since we published that report, the COVID-19 pandemic has undoubtedly had a significant impact on bringing mental health and mental wellbeing to the forefront of the public consciousness.

In April 2022, working with the LGSCO, we published new guidance on providing Section 117 aftercare for people who have previously been detained under certain sections of the Mental Health Act. This drew on our joint investigation into a local authority, NHS trust and clinical commissioning group's (now integrated care board) failure to provide good care for a young woman in Croydon, South London. The case detailed how the lack of care after her discharge from a section, a legal entitlement, led to a severe deterioration in her mental health, put her at greater risk of harm and placed a huge emotional toll on her family, who struggled to get her the help she desperately needed.

Case studies: failings in patient, family and carer involvement in discharge planning

The most common failing we see in our casework involving discharge planning in mental health services (and in our health casework more broadly) is the involvement of patients, their families and carers in decision-making.

Patients' own views are sometimes not fully considered when services are making decisions about the risk of discharge from inpatient care. The long-promised reform to the Mental Health Act aims to give people detained under it as much involvement as possible in their own care planning.

We cannot underestimate the importance of communicating effectively with families and carers about the day discharge happens. If families are not expecting discharge, or are unable to prepare for it, then patients are not given the best chance of being able to stay at home with the right support.

The cases we have investigated show where the duty to take a person-centred view of discharge has not been met. The planning for where an individual is being discharged to and their support system beyond the hospital, including signposting to voluntary and community sector organisations, has not been good enough. To break the readmission cycle, a joined-up view of the social factors involved in this transition is just as important as looking at the physical or mental health aspects.

Case study 1: Trust not involving a patient's family in discharge risk assessment and giving incorrect information on self-help support after discharge

The complaint

Mr N was experiencing low mood and had privately expressed suicidal thoughts to his family. He was also using drugs as a coping mechanism for his mental health issues.

After an altercation, Mr N rang the police and told them he was having suicidal thoughts. The police took him to a hospital emergency department.

The local mental health Trust did a risk assessment before discharging Mr N the same day, with a care plan and contact information for self-help support organisations. But the contact details for these organisations were out of date. He tried to call them but could not get in touch with most of them.

The Trust did not involve family and carers in the discussion about Mr N's discharge.

Mr N contacted his GP and they put in place a medication and follow-up plan. He sadly took his own life a month later.

What we found

If the Trust had consulted with the family, it might have reached a different assessment of risk level. Information from the family could have provided a fuller picture of Mr N's mental health concerns and could have been valuable to the Trust's psychiatric liaison team in its assessment.

In line with NICE guidance, the Trust should have contacted a local drug and alcohol recovery support group on behalf of Mr N, which would have increased the chances of a more successful follow-up.

We found that the Trust's care had not met its own standard for family and carer involvement as well as best practice guidance set out by the Royal College of Psychiatrists and The Carers Trust. The Trust accepted this failing.

We recognise that a more thorough risk assessment, with documented input from family and carers, may have led to more support for Mr N. It is also possible that if Mr N had successfully made contact with mental health support organisations, he may have been able to access further assessment and therapies.

More than one month had passed from the time Mr N last received care from the Trust. We could not say the service failings were a direct cause of his death, but the uncertainty of not knowing if more intervention or in-depth assessment might have prevented Mr N's death was a significant injustice for his family.

Putting things right

Following our recommendations, the Trust put in place a system for regularly checking the accuracy of leaflets provided at discharge to make sure this does not happen again.

The Trust apologised to Mr N's family for not following best practice and briefed staff that, where possible, clinicians should lead on referral to other support services, including mental health organisations and drug and alcohol recovery support services.

Case study 2: Close family not updated on day of patient's discharge from hospital

The complaint

Ms E had been detained in hospital under Section 3 of the Mental Health Act for urgent treatment. After being discharged from the section, she stayed in hospital as a voluntary patient to continue treatment.

She was granted leave over Christmas to visit family and returned to hospital in the new year. She was granted another week of leave before the hospital held a review to make a discharge plan. Ms E was joined by her mother-in-law for the discharge meeting, with the aim to fully discharge her by the end of the day.

Ms E's partner said staff had not communicated with him or invited him to any review meetings, including the discharge meeting. The Trust said it did not need the consent of close family members when discharging patients, although it encourages patients to invite family to be part of the discussion.

What we found

According to the principles of 'The Care Programme Approach', which was in place at the time of Ms E's hospital admission, individuals have a choice about whether to consent to involving their families in planning and decision-making if they have capacity to.

As a voluntary patient, Ms E had capacity to consent and was free to invite who she wanted to the planning meetings. But there was still a responsibility on the Trust to make sure it got the views of everyone involved in the care plan, even if they did not attend the review meeting.

We could see that Ms E's partner had said he wanted her care records before she was discharged and an update from staff before overnight leave was granted. Staff were happy to give this reassurance.

But there was no evidence that the Trust contacted Ms E's partner to discuss her progress before her final discharge from the hospital, even though Ms E had consented to her partner being updated. Ms E's partner and children were unprepared and not reassured about her discharge and return home that day. This caused distress for the family and made an incredibly difficult time even worse for them.

Putting things right

We recommended that the Trust should apologise to Ms E's family for the impact of failing to update all of them about Ms E's progress before it discharged her. We said it should explain how it will make sure it follows its own plans before discharging patients in the future.

Case study 3: Failings in how a Trust assessed a patient when they requested to be discharged

The complaint

Ms A had a history of anorexia nervosa (an eating disorder and serious mental health condition), depression, anxious personality disorder (a mental health condition that affects how someone thinks, perceives, feels or relates to others) and autism. She had received care from the Trust on various occasions over a six-year period.

She began to have suicidal thoughts and made several attempts to take her own life. After one attempt to take her own life, Ms A was taken to hospital by ambulance and later admitted to an inpatient mental health unit. During her stay, the Trust discussed a plan to reduce and eventually stop some of her medications. Ms A was unhappy about these changes and asked to be discharged. The Trust agreed to discharge her.

After Ms A attempted to take her own life the following day, she was readmitted and then discharged from the emergency department the next day, with follow-up from a psychiatric liaison team. Care coordinators had put plans in place for video consultations. When the Trust could not contact Ms A two days later and a police welfare check was ordered, it was found that she had sadly taken her own life.

What we found

We found failings in how the Trust assessed Ms A when she asked to be discharged from the mental health unit. Documentation for the assessment lacked detail to show that the team had approached Ms A's request with sufficient professional curiosity. We would expect staff to ask and challenge Ms A on what had changed during the admission to lead her to no longer feel suicidal and how they could support with any concerns about medication changes. The Trust had not explored whether discharge was genuinely the best option for Ms A at that time.

Although the Trust's decision not to detain Ms A was in line with the Mental Health Act code of practice, there was a missed opportunity to try and advise Ms A to stay in hospital.

But we found that the Trust's actions in the immediate lead-up to Ms A's death were appropriate.

Putting things right

We recommended that the Trust should apologise to Ms A's family for failing to do the assessment correctly. We also recommended that it make a payment to recognise that the family have been left not knowing whether Ms A's death could have been avoided.

We also said the Trust should produce an action plan to show how it will prevent similar failings from happening again. And that it should share this with Ms A's family, us, the CQC and NHS Improvement

Case studies: poor record-keeping

One of the central parts of the previous NHS Care Programme Approach (the standard for coordinating care around the needs of mental health service users), which was in place until September 2019, was having a written care plan that is jointly agreed with members of the multidisciplinary team, GP, individual patient, carers and any other relevant agencies.

This plays an important role in transitions of care from inpatient to community settings. Care plans should include:

- contact details for the care coordinator
- arrangements for the individual's mental and physical health care
- any factors that suggest an individual is becoming unwell and what to do if this happens.

Poor record-keeping can directly affect patient safety. Care plans that are missing or not managed well can have significant negative consequences for care, at that time and in the future. Poor management of care plans also affects family, carer and patient involvement in planning for discharge.

When complaints about care are made, poor records can worsen the distress for complainants and their families. They can be left not knowing how decisions were made and whether a different outcome could have been possible. Without adequate records, we can also be prevented from getting answers to our questions and making sure accountability and learning can take place.

Case study 4: Poor record-keeping around discharge planning and sign-off

The complaint

Mr L was admitted several times to a mental health assessment unit, an extension of a Trust's emergency department, after repeated attempts to take his own life. Each time he was discharged after psychological and risk assessments were done.

Sadly, after a third admission and discharge, a family member found Mr L had died at his home.

What we found

To provide appropriate discharge planning, either a multidisciplinary team or consultant psychiatrist should be involved in discharge decision-making. The Trust said the multidisciplinary team was involved, but we saw no evidence of this in the records.

We found that the Trust did not update Mr L's medical records in line with its own policy. This represented a service failure. Although we did not find that this failure affected Mr L's health or wellbeing, it caused unnecessary distress to his family as it created uncertainty about the quality and safety of the care he received in the lead-up to his death.

We were also left unable to give a firmer view on the sign-off process of Mr L's final discharge.

Putting things right

We recommended that the Trust should apologise to Mr L's family for its failings in record-keeping, which denied them the right to fully understand what had happened to their loved one.

We also recommended that the Trust should provide Mr L's family and us with evidence of how it will make sure staff complete patient records in line with its records management policy.

Case studies: poor communication between clinical professionals and teams in planning transfers of care

Discharge from mental health services or transfers of care usually involves multiple teams and professionals. This means decision-making can be incredibly complex and challenging.

Effective communication between professionals who understand the aims and potential risks of discharge is vital to make assessments and planning as comprehensive as possible. Poor joint-working across clinical professionals, and between physical and mental health expert teams, results in quick readmission. This shortfall is especially severe in the case of eating disorders where cross-team, and sometimes cross-trust, management is vital.

Case study 5: Failure to carry out a Mental Capacity Act (MCA) assessment before discharge

The complaint

Mr S was admitted to an acute Trust hospital with leg swelling and shortness of breath. He was diagnosed with heart failure but experienced periods of mental ill health during his stay in hospital. Deprivation of liberty safeguards (where you are closely supervised and not free to go anywhere without permission) were issued to keep him safe and stop him leaving hospital.

A mental health team, from the local Foundation Trust which provided mental health services, assessed Mr S and noted he was sometimes disorientated and confused. Medical ward staff also reported that he had shown symptoms of a psychotic episode (psychosis is when you perceive or interpret reality in a very different way from people around you).

On another occasion where Mr S showed unusual behaviour, it was felt that a review by a consultant psychiatrist was needed so that a management plan could be put in place. The psychiatrist reported that Mr S's condition was mainly due to delirium (sudden confusion), along with heart and liver failure.

Two days later, the mental health Trust liaison assessment team reported that Mr S was now in a bright mood, orientated to time and place, and considered mentally and medically fit for discharge. He was discharged home.

Mr S was not able to take his medication correctly and was readmitted to hospital. Sadly, he had a fatal cardiac arrest (when the heart stops pumping blood around the body) eight days later. His family disputed whether he had been mentally fit for discharge.

What we found

We found that although a pre-discharge assessment had been completed, which was in line with the mental health Trust's policy, this was not comprehensive enough. A more detailed MCA should have taken place because staff had noted concerns about Mr S's behaviour. We found evidence that a psychiatrist had recommended an MCA, but this was not followed up.

The MCA would have allowed the team to make a more informed decision about Mr S's discharge. The lack of MCA was not in line with the Mental Capacity Code of Practice. It was a failing as the assessment process was not as robust as it should have been.

Putting things right

We recommended that the Trust should acknowledge its failings in care and apologise for the impact on Mr S's family, who will never know if the discharge decision and outcome could have been different.

Case study 6: Poor joint-working led to multiple transfers of care and emergency hospital readmissions

The complaint

Ms I began to experience severe anxiety around food and drink. She was admitted to the hospital's emergency department due to her reduced eating, drinking and weight loss.

A gastroenterology team (specialists in the digestive system) led the investigations initially and involved a mental health team at a different Trust to explore Ms I's severe anxiety symptoms. The mental health team visited regularly while she was in hospital.

Due to Ms I's reduced food intake, the Trust fitted a feeding tube. It felt that her inability to eat and drink was likely caused by a psychological issue and needed mental health treatment. The tube was then removed and Ms I's care was transferred to a crisis home under the supervision of the mental health team.

In the proposal to discharge, the mental health team noted that Ms I coped well with the feeding tube and raised concerns that if it was removed, a quick readmission to hospital would be likely. The Trust's reason for removing the tube was valid but it should have taken on board the mental health team's recommendation to continue providing nutritional support. Just two days later, Ms I was readmitted due to dehydration and the feeding tube was reinserted.

Three months later, Ms I was admitted to a mental health inpatient unit. The following month, a diagnosis of avoidant/restrictive food intake disorder (ARFID) was made.

A feeding tube blockage led to an emergency admission and a subsequent transition of care to the mental health inpatient unit without replacing the tube. Two days later, the Trust readmitted Ms I because she had not eaten or drank anything. The tube was reinserted after two more days.

What we found

We found that, although it was right not to immediately replace a feeding tube to see if Ms I could tolerate food and drink, the gastroenterology team should have followed advice from the mental health team around the need to provide nutritional support. This was particularly important when it was clear Ms I was unable to eat or drink properly herself.

Repeatedly being left without food and medication during these periods traumatised Ms I, increased her anxiety and caused significant distress to her wider family. More likely than not, had the feeding tubes been replaced sooner, at least some of the succession of readmissions to hospital could have been prevented.

There are no established NICE guidelines for managing ARFID as it is a relatively newly recognised eating disorder. But this should not have stopped the gastroenterology team and mental health team from working together to agree a joint feeding and treatment plan, and listening and working together more effectively to provide better care for Ms I.

Putting things right

We recommended that the Trust apologise to Ms I and her family and make a payment to recognise the impact of its failings. We also recommended that the Trust should show us and Ms I what action it has taken to make sure its review of practices for patients at risk of malnutrition and under the care of a mental health professional addressed the failings we identified.

Recommendations

Recommendation 1

We note the Department of Health and Social Care's (DHSC) national statutory guidance on discharge from mental health settings. As it is implemented, DHSC and NHS England must engage with people and services to assess the impact the guidance has on them. In particular, they must make sure that Integrated Care Systems account for the different professionals that should be involved in the discharge multi-disciplinary team (MDT).

To make sure transitions of care consider a patient's full condition and situation, an MDT must be involved in discharge planning and delivery. This team should include representatives of the different points in a patient care pathway. This will create a 'safety net' of care around a person when they leave an inpatient setting. The MDT members should be seen and referred to as equal partners in someone's care.

Each transition of care should include or state the reasons for excluding:

- the current inpatient mental health team
- other medical specialities involved in an individual's physical health care
- occupational therapists
- dieticians (for example, for individuals with a diagnosed eating disorder)
- the community mental health team or a representative from primary care
- the crisis response team
- voluntary and community sector partners involved in support services
- a mental health social worker, where relevant
- a local authority representative responsible for housing, where relevant.

Integrated care boards are in a good position to help bring together these different partners to make sure planning for transitions in care is safe and patient-centred.

A patient's care plan on discharge must clearly reflect the involvement of each of these teams.

Recommendation 2

NHS England should extend the requirement for a follow-up check within 72 hours of discharge for people from inpatient mental health settings to include people discharged from emergency departments.

When someone is discharged from inpatient mental health services, they should have a follow-up appointment within 72 hours of leaving hospital. This is usually led by the community mental health team or crisis mental health team and is informed by evidence from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). If a person in a mental health crisis goes to a hospital emergency department and is assessed, they may be treated, transferred to a mental health ward or sent home. Depending on clinical assessments, a support plan may be put in place with a community mental health team, but it may take time for this to happen.

When a lead emergency department clinician or psychiatric liaison team is discharging someone from an emergency department to their home, they should confirm or rule out a follow-up call or appointment with a crisis mental health team, care coordinator or primary care provider within 72 hours.

This applies the principles of safe transitions of care and discharge to emergency admissions and assessments.

Recommendation 3

NHS England and integrated care boards (ICBs) should make sure that people who are being discharged from mental health settings can choose a nominated person to be involved in discussions and decision-making around transitions of care.

In the absence of reform to the Mental Health Act, guidance should state that people are asked to name a nominated person who they would like to be included throughout the planning and transition of their care. As set out in the draft Mental Health Bill, this nominated person would replace the 'nearest relative' role and could be a close relative, carer or another trusted person. The nominated person should be able to support the individual in advocating for their wishes and concerns in the transition of care. Healthcare professionals should listen to the nominated person's views and record them alongside the views of the person who is having their care transferred.

Other people including family members and carers should still be informed and updated on discharge plans.

Recommendation 4

NHS England should make sure that patients and their support network are active and valued partners in planning transitions of care and are empowered to give feedback, including through complaints.

We welcome the ambition set out in NHS England's forthcoming 'Culture of Care Standard for Mental Health Inpatient Services', including the core commitments around 'choice' (the right for patients and their support network to be engaged in all parts of care) and 'transparency' (open and honest conversations with all people involved in someone's care). We know that inpatient mental health settings are at greater risk of developing 'closed cultures', so national leadership is needed to build and maintain an open culture.

As the standards are rolled out over 2024, mental health services and integrated care boards must be held to account for making sure that:

- the views and experiences of individual patients, their families, carers and nominated person are held in balance with any clinical perspective in making decisions about transitions of care
- staff support and encourage people to use this right and, in the case of someone being detained under certain sections of the Mental Health Act, listen to the views of an individual, their family and carers before making a clinical decision
- people are empowered to give feedback about their or their loved-one's care and staff proactively seek out their feedback
- when things go wrong in care, people affected are supported to make a complaint and know that this will be responded to in an honest and compassionate way. Where necessary, services must effectively signpost and support people to take their complaint to the appropriate organisation, such as the Parliamentary and Health Service Ombudsman, Local Government and Social Care Ombudsman, Care Quality Commission or Mental Health Tribunal.

Recommendation 5

The Government must show its commitment to transforming and improving mental health care by introducing the Mental Health Bill to Parliament as a priority.

People using mental health services need their safety and rights to be protected. Patients, families, carers, staff and commissioners of care need a twenty-first century Mental Health Act so they can receive and deliver modern mental health care.

Modernised and strengthened legislation must prioritise patient safety and experience and put the voice of people, their families and carers at its heart. We welcome the terms of the draft Mental Health Bill as a whole.

In future draft versions of the Mental Health Bill, we need to see legislation that:

- removes barriers to accessing justice for mental health patients by including mandatory signposting to the Parliamentary and Health Service Ombudsman, Local Government and Social Care Ombudsman, Care Quality Commission or the Mental Health Tribunal as appropriate for the type of complaint
- allows people to complain to us in the most suitable way for them. This should not be in writing only as this discriminates against people who may find it difficult to communicate their experiences of care in this way, including:
    - people living with severe mental health conditions
    - people with specific accessibility needs
    - people who do not have English as their first language.

Policy and practice: opportunities for change

Although this report focuses on failings in discharge and transitions of care from our casework, it is important that we position this in line with the opportunities that are available to policymakers, practitioners and health leaders to make service improvements. This is so they can act on the learning from these cases and make sure we get transitions of care right the first time for people and their families.

Reform to the Mental Health Act

The main law for providing Mental Health care and securing the rights of people detained under a section in the UK is still the 1983 Mental Health Act. After the Government published its 'Reforming the Mental Health Act' white paper in 2021, the draft 'Mental Health Bill' was published in June 2022 and detailed government ambitions to bring the law up to date.

In our response to the pre-legislative scrutiny stage of the bill, we supported the proposals to improve the safety and quality of patient care for people detained under the Act and the ambition to increase the power of patients, families and carers. Steps to give more choice and autonomy to people would make treatment more person-centred. We welcomed the proposal for a statutory duty to create a care and treatment plan for every person detained under the Act and that all relevant parties are included in decision-making.

One of the major failings identified in our casework around discharge is the lack of involvement of families and carers around important decisions. Enshrining this in law would go some way to building the foundations for discharge care and planning that puts people, their carers, loved ones and safety at its heart.

We are disappointed by the lack of government progress to bring the desperately needed proposed reforms into law. The long overdue Mental Health Bill is an opportunity to overhaul the way the system works when people are in a mental health crisis and make it fit for the twenty-first century.

Mental health campaigners have worked tirelessly for the reform of this law. Their voices must not go unheard, and we will continue to support calls for reform.

Moving from the Care Programme Approach to the Community Mental Health Framework

NHS England's 'Community Mental Health Framework for Adults and Older Adults' explains how health systems should put the NHS Long Term Plan into practice to deliver place-based community mental health care. Published in 2019, it proposed replacing the 'Care Programme Approach' (CPA) which had been the guiding principles for delivering care in the community for people diagnosed with a mental health condition. The CPA was brought in during the early 1990s.

The Community Mental Health Framework resulted in 12 early adopter systems getting funding to develop new models of care in line with its principles. It is intended that all health systems will be expected to put in place similar new models by 2024, supported by new investment in relation to the new NHS Long Term Plan.

The principles of the framework are:

- meaningful intervention-based care (rather than generic care coordination)
- a named key worker for all service users supported by a clearer multidisciplinary team
- co-produced, holistic and personalised care and support planning for people living with severe mental health conditions in the community
- better support and involvement of carers
- a more accessible, responsive and flexible system tailored to the health, care and life needs of an individual.

For discharge pathways and support specifically, the framework refers to the ambition of 'maximising continuity of care' to make sure there is no care 'cliff-edge'. It aims to end a system that is centred around 'referrals, arbitrary thresholds, unsupported transitions and discharge to little or no support'. Instead, it represents a 'move towards a flexible system that proactively responds to ongoing care needs'.

Rethink Mental Illness reviewed the first year of the Community Mental Health Framework in 2022 and found that 'systems are at different stages on their journey towards co-production'. Although there was significant evidence of local innovation, challenges could not be 'fully addressed at a local level'. At this point it was deemed 'too early to truly evaluate the extent to which its potential is likely to be fully realised' ('Getting Started: lessons from the first year of implementing the Community Mental Health Framework', page 34).

'Suicide prevention in England' policy paper

Published in September 2023, the Department of Health and Social Care's 'Suicide prevention in England: 5-year cross-sector strategy' identifies the following priorities for action:

- improve data and evidence around suicide to ensure effective and timely interventions continue to be developed
- tailored support to priority groups including those at higher risk
- address common risk factors at a population level to provide early intervention
- promote online safety and responsible media content to reduce harm and improve support
- provide effective crisis support across sectors
- reduce access to means and methods of suicide
- provide effective bereavement support to those affected by suicide
- make suicide 'everybody's business' to increase collective impact.

In relation to discharge, the paper references a continuing need to make progress on early follow-up on discharge, particularly in the first 72 hours of a person leaving inpatient settings but also through developing 'effective integrated pathways'.

Guidance developed by safety planning working groups, including around training and quality improvement, will be published by March 2024 with delivery to begin by March 2025.

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