Annex D – 'Discharge from mental health care: making it safe and patient-centred' report summary (February 2024)

In PHSO's February 2024 report, 'Discharge from mental health care: making it safe and patient-centred' (evidence), PHSO analysed more than 100 complaints between April 2020 to September 2023 and found failings specifically around discharge from inpatient mental health services and discharge from emergency departments when someone presented in mental health crisis. The cases highlight issues in planning, communication and care, both during and after discharge, which can lead to poorer outcomes for patients and the risk of repeated cycles of readmission.

Two of the cases spotlighted in the report related to care provided in by Trusts in Essex. (Case summaries entitled 'Poor record-keeping around discharge planning and sign-off' and 'Close family not updated on day of patient's discharge from hospital').

PHSO made five key recommendations in this report, namely:

- DHSC and NHS England must engage with people and services to assess the impact statutory discharge guidance has on them. They must ensure that Integrated Care Systems account for the different professionals that should be involved in the discharge multi-disciplinary team (MDT).
- 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.
- 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.

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

On publication of the report, all Trusts featured in the report were contacted. The Ombudsman wrote to the Mental Health Minister, Shadow Secretary of State for Health and Social Care, Chair of PACAC and the Health and Social Care Select Committee as well as the National Mental Health Director at NHS England. The report launch saw good engagement within Parliament (a debate chaired by the Shadow Minister for Mental Health on the report) as well as in the press and amongst wider relevant sector stakeholders.

Following publication of our report, the Department for Health and Social Care (DHSC) commissioned a national review of best practice in mental health discharge led by the Secondary Care and Integration team. This work remains ongoing and we are regularly updated on progress.

We continue to have constructive and positive engagement with NHS England Quality Transformation Team for Mental Health, Learning Disability and Autism and welcomed the rollout of their 'Culture of Care' standards for mental health inpatient services, launched in 2024.

We have also engaged on the issues raised in the report with third sector partners including the Association of Mental Health Providers, Rethink Mental Illness, NHS Confederation Mental Health Network and the Royal College of Emergency Medicine.

The report findings have also been referenced in CQC's review and inquest into failings in Nottingham in relation to the care and discharge of Valdo Calocane.