Discharge planning

In January 2024, NHS England introduced statutory guidance on Discharge from mental health inpatient settings. This sets out how organisations across the health system should work together to ensure effective discharge planning and that people who are discharged receive the best outcomes. This guidance emphasises the importance of involving people who use services and their chosen carers. It is clear that discharge planning should start before or on admission, and should be continued throughout a person's stay in hospital. This reflects current guidance in the MHA Code of Practice, which states that discharge planning should begin as soon as a patient is admitted under the MHA.

As part of our review of VC's care and treatment and the 10 cases reviewed for benchmarking purposes, we looked at the discharge plans (where appropriate) for each individual and how discharges were managed by the trust.

Our review showed that discharge planning for VC only really looked at how he was presenting at the point of each discharge, the context of his individual admissions to hospital and how he had recovered during those stays. VC appears to have complied with taking his medicine when he was in hospital, and his symptoms often improved.

In addition, discharge plans did not take a more holistic view of his previous patterns of admission following relapse after he had stopped taking his medicine in the community. They did not also look at what was required for successful recovery in the community.

Three out of 4 of VC's inpatient stays were in NHS hospitals in the Nottingham area, with one admission (his third admission) out of area to an independent hospital in the North East, during which he was transferred back to an independent hospital in Nottingham. We found no issues with the first 2 discharges between local NHS hospitals and community services. This reflects some of the findings from our review of 10 benchmarking cases, which found that, of the 4 patients discharged from NHFT, 3 were handled well.

There were differences between the records we reviewed from the trust and the independent hospital in relation to the third discharge in October 2021. As noted in the section on Engagement with VC and his family, NHFT records show that discharge from the hospital was unexpected and the EIP team were only told he had been discharged when they contacted the hospital about attending his ward round. Records from the independent hospital showed that they had contacted the EIP team before his discharge. VC's family were not told by the hospital that he was being discharged.

We highlighted problems around people not being involved or notified in discharge decisions in our first report on NHFT. In this, we also reported on difficulties in transitions of care for people discharged from inpatient services or the crisis team into community care. For example, we found multiple incidents of people being discharged from inpatient services without the support of community mental health teams in place, or a lack of timely follow-ups from the community mental health team.

In our wider review, some people told us that moving between services felt fragmented while others described issues including being discharged "too soon" or leaving inpatient services in a "worse state" than when they arrived. Some people felt they were not ready to be discharged, especially if they had been receiving support for a long time, or there was no emergency plan or community support in place before being discharged. This could lead to people being re-admitted to services very soon after discharge or rapidly deteriorating in the community.

As part of the step down process, VC should have been discharged to the CRHT team, but the discharge occurred on a Friday and no crisis team input had been arranged over the weekend. The EIP team attempted to refer him to the crisis team, but they were unable to accept his case due to capacity issues. In place of any other input being available, the EIP team took on his care and treatment.

Not having access to the CRHT team means that VC did not receive the specialist support required, which may have increased the risk that his transfer of care back into the community may not be successful.

In both his third and fourth admissions to hospital, discharge planning did not address or take into consideration the previous failures to maintain recovery in the community, which had led to him relapsing and becoming violent.

Ahead of his third discharge, a forensic assessment could have helped with understanding the level of risk and supporting a risk management plan, but this was not considered. There was also no risk assessment or multidisciplinary team meeting ahead of this discharge. The multidisciplinary meeting would have enabled the views of the care co-ordinator, EIP consultant and psychologist to be considered together, and supported the community team to identify risk and treatment challenges. This was a missed opportunity to inform decisions about discharge planning, including for example the use of depot antipsychotic medicine and a community treatment order (CTO), for which there was clear indication.

CTOs allow suitable patients to live in the community rather than being detained in hospital, to help prevent relapse and harm. Patients placed on a CTO have to meet certain conditions which may include, for example, living in a certain place, attending appointments with mental health professionals, or not taking drugs and drinking alcohol. If they don't comply, they may be recalled to hospital under the MHA. Decisions around CTOs are made by the responsible clinician, and can be applied to people who are detained under section 3 of the MHA. People under section 2, or who are already discharged from hospital, cannot be placed on a CTO.

Despite known risks around VC not taking his medicine in the community, and the risk he posed when non-compliant, there is no mention of a CTO, combined with the use of depot injection, until his fourth admission. Records show that at this admission, the community team raised it as a potential discharge approach.

As highlighted in the sections in this report on Engagement with VC and his family and Medicines management, NICE guidelines recommend the use of depot antipsychotic medicine for people who do not comply with taking oral medicines. In addition, community treatment orders (CTO) are designed to support people in the community to maintain stable mental health outside of hospital and promote recovery. Giving VC a depot injection and placing him on CTO would have allowed for recall to hospital if he stopped taking his medicine in the community. But as he was being held under section 2 of the MHA it was not legally possible to discharge him using a CTO.

VC's discharge on oral medicine was based on his assurances that he would continue to take his medicine. However, by this time he had a significant history of not taking his medicine after discharge from hospital, which posed a risk to others when not taking his medicine, which should have been considered.

The evidence over the course of VC's illness and contact with services and police indicated beyond any real doubt that VC would relapse into distressing symptoms and potentially aggressive and/or intrusive behaviour if he was not treated with antipsychotic medicine and monitored in the community.

As a result, the decision to discharge VC from community mental health services back to his GP in September 2022 due to non-engagement did not adequately consider or mitigate the risks of relapse and violence due to his persistent poor insight and resistance to treatment, which were symptoms of his illness.

This reflects the findings from our wider review of NHFT, which highlighted that discharge planning across the community mental health and crisis services was not robust, and that there was a 'lack of clarity of thinking' in relation to discharge decisions.

© Care Quality Commission