Healthcare Improvement Scotland

Quality Improvement Methodology Report: Reducing Delayed Discharges in Mental Health & Learning Disability Services

NHS Grampian, Royal Cornhill Hospital

This report is intended for professionals involved in the management of delayed discharges within mental health and learning disability services. It highlights key themes such as optimising patient flow, enhancing discharge planning processes, and addressing the challenges of complex case management.

1. Background and context

Reducing delayed discharges from mental health inpatient facilities is a priority in enhancing the quality, safety, and efficiency of patient care. Delays in discharge not only disrupt patient recovery and continuity of care but also place significant pressure on inpatient capacity, limiting access for those in urgent need of admission. Addressing this issue requires a coordinated, system-wide approach that removes barriers to timely discharge, strengthens collaboration between services, and ensures patients receive the right care in the right setting.

As part of the national mission to reduce delayed discharges across the NHS in Scotland, Healthcare Improvement Scotland and NHS Grampian worked together on a Quality Improvement (QI) focused project to begin addressing issues related to delayed discharges at Royal Cornhill Hospital.

Royal Cornhill Hospital (RCH) in Aberdeen City has a bed complement of around 400 and provides a comprehensive range of general and specialist psychiatric services, including adult acute admission, rehabilitation, forensic, older adult mental health and learning disability.

2. Key learning points

- **Early discharge planning is essential** — it should start at admission, not when treatment is complete.
- **Good communication underpins success** — regular joint meetings where discharge is everybody's business.

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- **System-wide collaboration is essential** — housing, social work, and voluntary partners must be engaged early.
- **Escalation pathways matter** — complex cases need creative focus and timely senior oversight to avoid drift.
- **Patient, family and carer voice must be central** — unnecessary delays can cause anxiety, loss of independence, and mistrust.
- **QI methodologies (PDSA, run charts, process mapping)** help structure improvement and track progress.

3. Problem statement

NHS Grampian identified that delayed discharges accounted for a significant proportion of occupied bed days across its Mental Health and Learning Disability (MH/LD) inpatient units at RCH.

Impacts included:

- high bed occupancy and reduced capacity to admit new patients in crisis
- negative impact on patients' wellbeing and outcomes
- increased costs to NHS Grampian and the wider health and social care system, and
- staff frustration, with local teams reporting "going round in circles" when trying to discharge complex cases.

4. Why this matters to patients

When individuals are delayed in hospital after they are clinically ready to leave, they lose valuable opportunities to reintegrate into their communities and continue their recovery away from a hospital environment.

These delays can increase feelings of frustration, dependency, and stigma, while also placing pressure on already limited NHS inpatient resources. Exploring this issue through a brief example case study helps to highlight not only the human cost of delayed discharges but also the systemic barriers that contribute to them.

Example case study:

32-year-old person with moderate learning disability and personality disorder.

Reason for admission: Deterioration in mental health linked to a breakdown in community placement.

Progress: Stabilised after five weeks of inpatient support and assessed as ready for discharge.

The Problem: Discharge was delayed by four weeks due to:

- Discharge planning not started until late in admission and until patient was medically fit for discharge.
- Pre discharge communication challenges impacted on CMHT's ability to prepare timely follow-up.
- Property/tenancy not ready to occupy.
- No escalation until delay had already become prolonged.
- Patient expressed frustration, repeatedly asking why they could not go home, with potential that their condition could deteriorate whilst being delayed.
- Significant financial cost of hospital bed days.

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5. Improvement Aim

The specific aim of this programme was to achieve a 25% reduction in delayed discharges from the NHS Grampian RCH by the end of the programme period. This target was measurable through routine discharge data. This was achieved through focused collaboration across inpatient and community teams, relevant to improving patient flow and service efficiency.

Measures

The team measured the number of delayed discharges and delayed transfers of care recorded in NHS Grampian RCH.

Process

The team looked at the:

- percentage of patients with a Planned Discharge Date (PDD)
- reduction in the number of 'no updates' provided at the weekly delayed discharge meeting
- TRAK Care delayed discharge Tab implementation, and
- number of escalations for prolonged delayed discharges.

Outcome

A reduction in the number of delayed discharges.

Balancing

The number of patients removed from delayed discharge list due to deterioration in physical or mental health.

6. Understanding the Local System

Working together, using process and system mapping in person and virtual workshops, the improvement project team identified key contributors to delayed discharges:

7.1. Process issues

- Discharge planning often started only when a patient was clinically ready to leave.
- No standard operating procedures in place for discharge planning.
- No standardised approach to escalation when complex delays occurred.
- Low percentage of patients with a Planned Discharge Date (PDD).
- High number of 'no updates' at weekly DD meetings.

7.2. Communication barriers

- Fragmented communication between ward staff, community teams, social work/care, and housing providers.
- Patients and families not always updated regularly.

7.3. System factors

- Delays in securing funding for care packages.
- Significant increase in acuity of those presenting at RCH.
- Lack of available supported housing placements.
- Lack of available social care options.
- Complexities in multi-agency working (health, social care, housing and voluntary sector).
- Challenging financial landscape.

7.4. Cultural issues

- A perception among staff that “discharge resolution can feel outwith their control.”
- A lack of discharge progress updates at weekly delayed discharge meetings.
- Limited confidence/understanding in escalation processes.

7. Intervention Design

Throughout the cycle of the project, three tests of change were developed. The tests of change covered key areas identified by the local teams as priority areas to improve, including improved communication, a clear escalation process for those delays that become ‘prolonged’, and a standalone test that focused on early discharge planning from their older adult mental health ward.

Although the tests of change could not tackle some of the wider systemic issues in the system, it was agreed that a renewed focus on areas within their control and remit such as process rigour could have an impact on the number of delayed discharges within RCH.

8.1 Improving Communication Structures

- New policy: Discharge planning begins on the day of admission.
- Expected discharge date documented within first week.
- Weekly review of progress against discharge checklist.
- Weekly delayed discharge and delayed transfer of care meeting with ward, community, social work, and housing leads.
- Updated shared discharge tracker created (electronic spreadsheet accessible to all partners).
- Development and implementation of new discharge focused tab on TRAK Care.

8.2 Escalation Process

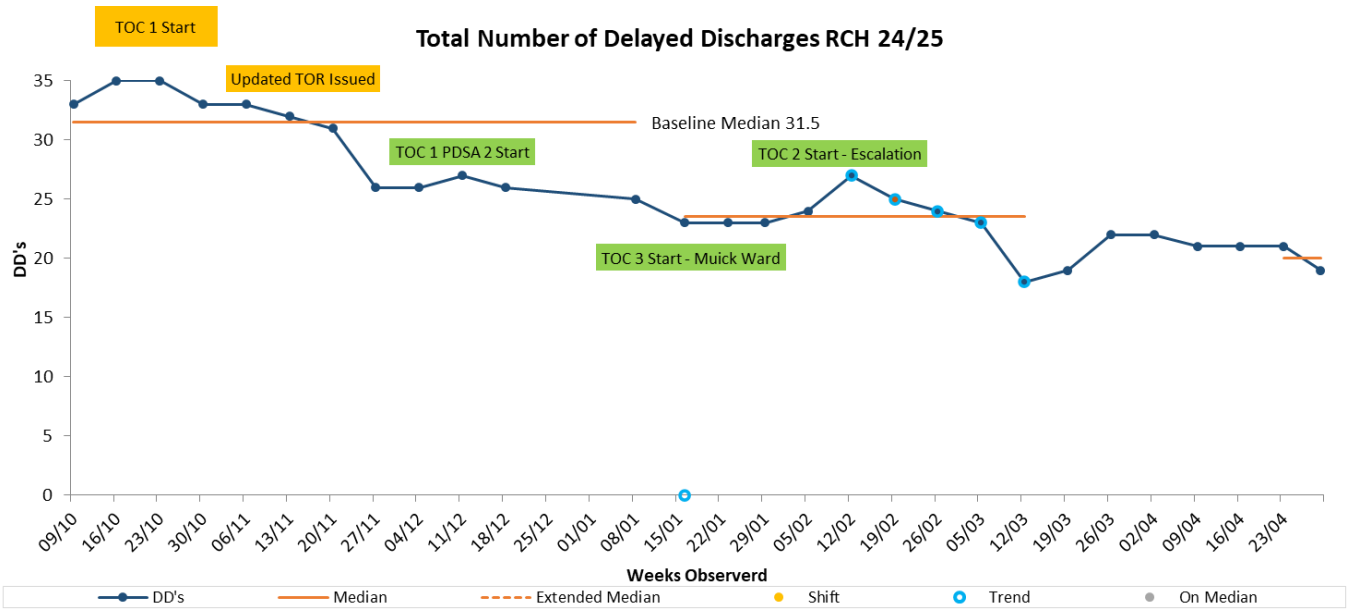
- Delayed discharge focus meeting established to address delayed discharges who have become ‘prolonged’ because of multi factorial and complex issues.

8.3 Early Discharge Planning – Older Adult Mental Health Ward

- Ward and community staff received training on effective discharge planning and communication.
- Development of new standard operating procedure for early discharge planning.
- Clear accountability with each patient allocated a named nurse from within the older adult mental health ward.
- Emphasis that *discharge is everyone's responsibility*.

8. Results

Since improvement work began across the three tests of change with RCH there has been a reduction of delayed discharges.



. 9.1 Trends and patterns

Average delayed discharge days reduced:

- 46% reduction in delayed discharges at RCH October 2024 to April 2025.
- 70% increase in patients with a PDD.

9.2 Test of Change 3 Results

Across test of change three which focused on earlier discharge planning in RCH Older Adult Mental Health ward (Muick Ward), significant improvements were made. The Older Adult Mental Health Ward has 20 beds.

Summary of results

- Staff reported **clearer processes** and **reduced** frustration with the delayed discharge process and improved communication noted across teams and with families/carers.
- **Improved patient flow - 46% increase** in standard discharges without delay over the six-month post-intervention period.
- **31% reduction** in incidents of delayed discharge (from eight patients to as low as one).
- **Reduction in length of stay (LoS)**: March 2024 LoS was 101 days, which decreased to 42 days in April 2025.
- **Reduction in total number of days spent as delayed discharge**: From 349 days in October 2024, which decreased to 61 days in April 2025.
- **20 discharges** achieved in a six-week period through proactive engagement during a period of civil contingency.
- **Readmissions**: Decreased post-intervention, though precise figures not recorded (as of yet).

9.3 Outcomes and Impact

Summary of outcomes and impact

- Greater integration of Community Mental Health and ward teams.
- Improved discharge flow and patient outcomes.
- Strengthened multi-disciplinary communication and planning.
- Increase in staff confidence and knowledge around discharge planning.
- Stronger leadership presence and positive team morale.
- Muick Ward recognised as an exemplar of good practice with plans to apply the learning to other wards in RCH.

9.4 Qualitative feedback

"New meeting processes support a more focussed approach, improved sharing of information, closer scrutiny of the barriers for progressing towards discharge including the identification of clear escalation processes."- **Nurse Manager, NHS Grampian**

10. Sustainability and spread

- Opportunities to scale to other wards within RCH (earlier discharge planning).
- Forming Phase 2 of the Mental Health and Learning Disability Delayed Discharge Programme with a learning system/change package.

11. Limitations

This improvement project focused on the main mental health inpatient facility in NHS Grampian. Through this work we have developed a Good Practice Overview (*see Appendix 1*) which will be tested and refined by working with three additional NHS Boards.

11. Conclusions and recommendations

Our work alongside colleagues in NHS Grampian pointed to the benefits of applying renewed focus to the process of delayed discharge. From an NHS Grampian perspective we made several recommendations that could help them to further improve and maintain patient flow and continue to reduce incidents of delayed discharges.

Recommendations

Consider implementing Crisis Support and Intensive Support Treatment Teams
Community-based mental health services are a key factor in supporting timely discharge, and prevention of admission. Developing the use of Intensive Home Treatment Teams and Crisis Teams locally could support improved system flow, admission rate and a further reduction of delayed discharges.

Consider implementing a dedicated Discharge Coordinator
Implementing a dedicated post with a specific focus on discharge co-ordination across mental health/learning disabilities could support and sustain improvements in reducing incidents of delayed discharge.

Continued focus and prioritisation of system flow and discharge planning
Applying a renewed focus on discharge planning that focuses on good communication, process rigour, appropriate escalation and earlier discharge planning can have a significant impact on delayed discharge numbers.

Appendix 1: Delayed Discharge and Patient Flow Good Practice Overview