Healthcare Improvement Scotland

The Delayed Discharge Improvement Programme: Mental Health, Learning Disabilities and Adults with Incapacity

National Learning System Launch

Leading quality health and care for Scotland

NHS SCOTLAND

Welcome and introductions

Introduce yourself in the chat box!

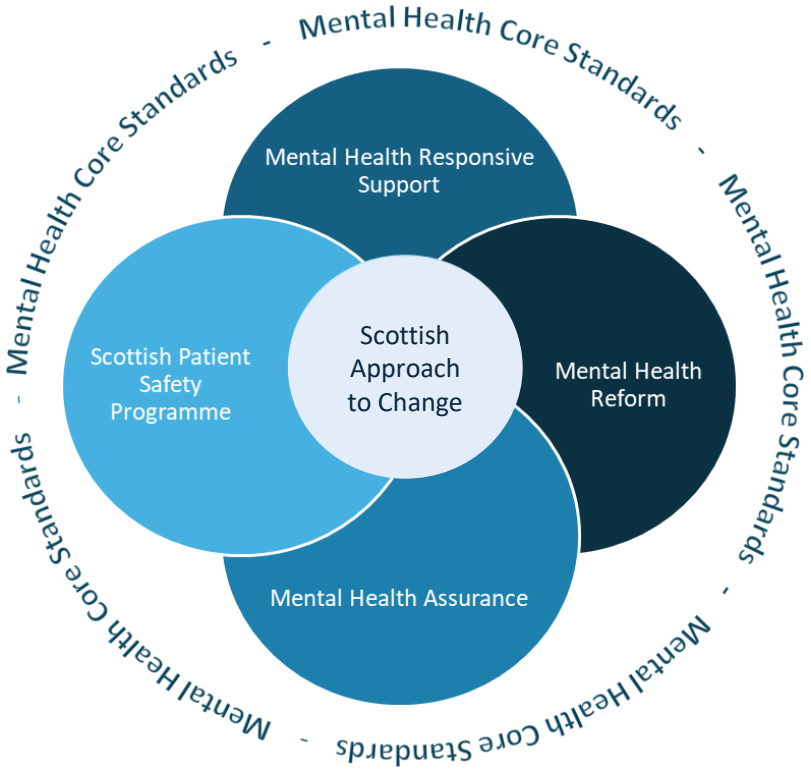
Tell us about yourself and what about this topic interests you

Diana Hekerem
Associate Director, Community Engagement and Transformational Change, Healthcare Improvement Scotland

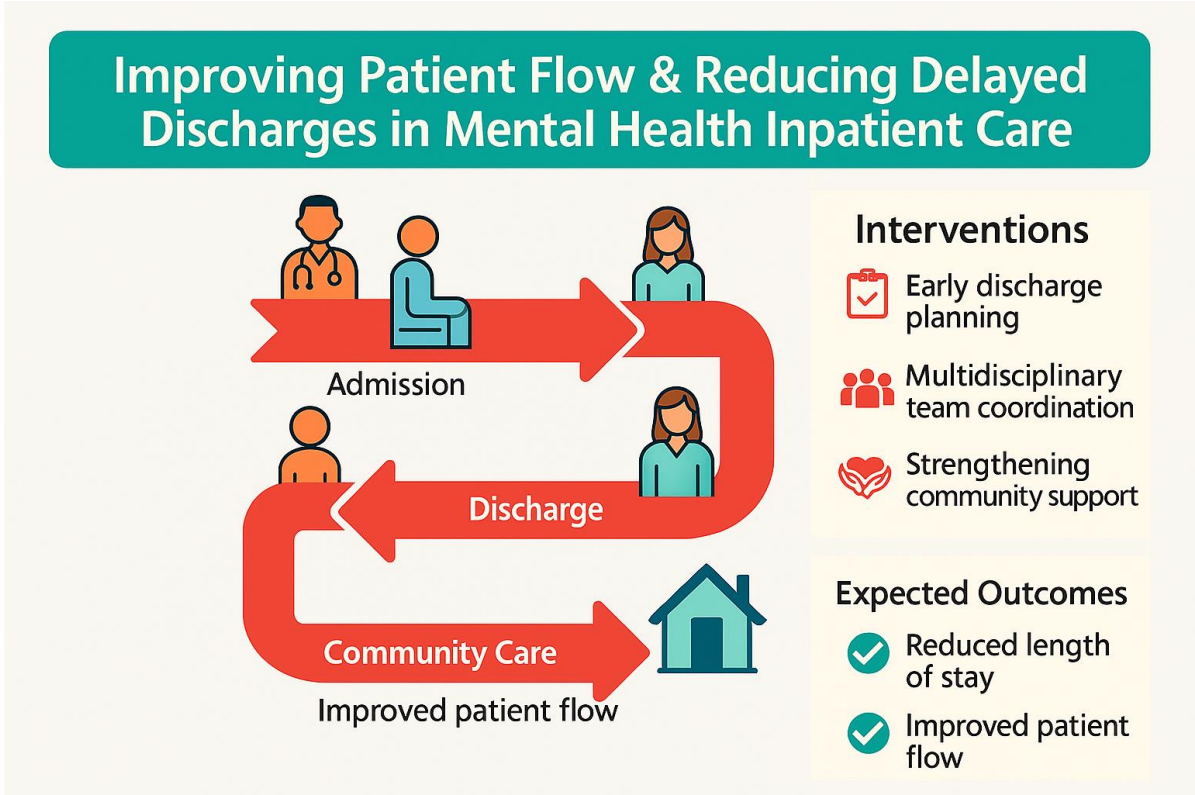
Agenda

Time	Topic	Lead
10am	Welcome and introduction to the Delayed Discharge Improvement Programme	Diana Hekerem - Chair (Associate Director, Community Engagement and Transformational Change, Healthcare Improvement Scotland)
10.15am	Overview of Mental Health work at Healthcare Improvement Scotland	Rachel King (Unit Head, Transformational Change and Mental Health, Healthcare Improvement Scotland)
10.20am	Overview of Phase 1 Delayed Discharge local Improvement work in mental health and learning disabilities	Gordon Hay (Senior Improvement Advisor, Healthcare Improvement Scotland) Rob Corrigan (Improvement Advisor, Healthcare Improvement Scotland)
10.40am	Adults with Incapacity learning and outputs	Clare Hammond (Unit Head, Systems, Healthcare Improvement Scotland)
11am	Sharing good practice from NHS Grampian - A clinician's experience	Claire Smith (Lead Nurse, Mental Health and Learning Disabilities Inpatient and Specialist Services and CAMHS, NHS Grampian) Kelly Evans (Senior Charge Nurse, NHS Grampian)
11.20am	Next steps for Phase 2 of the programme	Gordon Hay (Senior Improvement Advisor, Healthcare Improvement Scotland)
11.40am	Q & A	Diana Hekerem - Chair (Associate Director, Community Engagement and Transformational Change, Healthcare Improvement Scotland)
11.55am	Closing remarks	

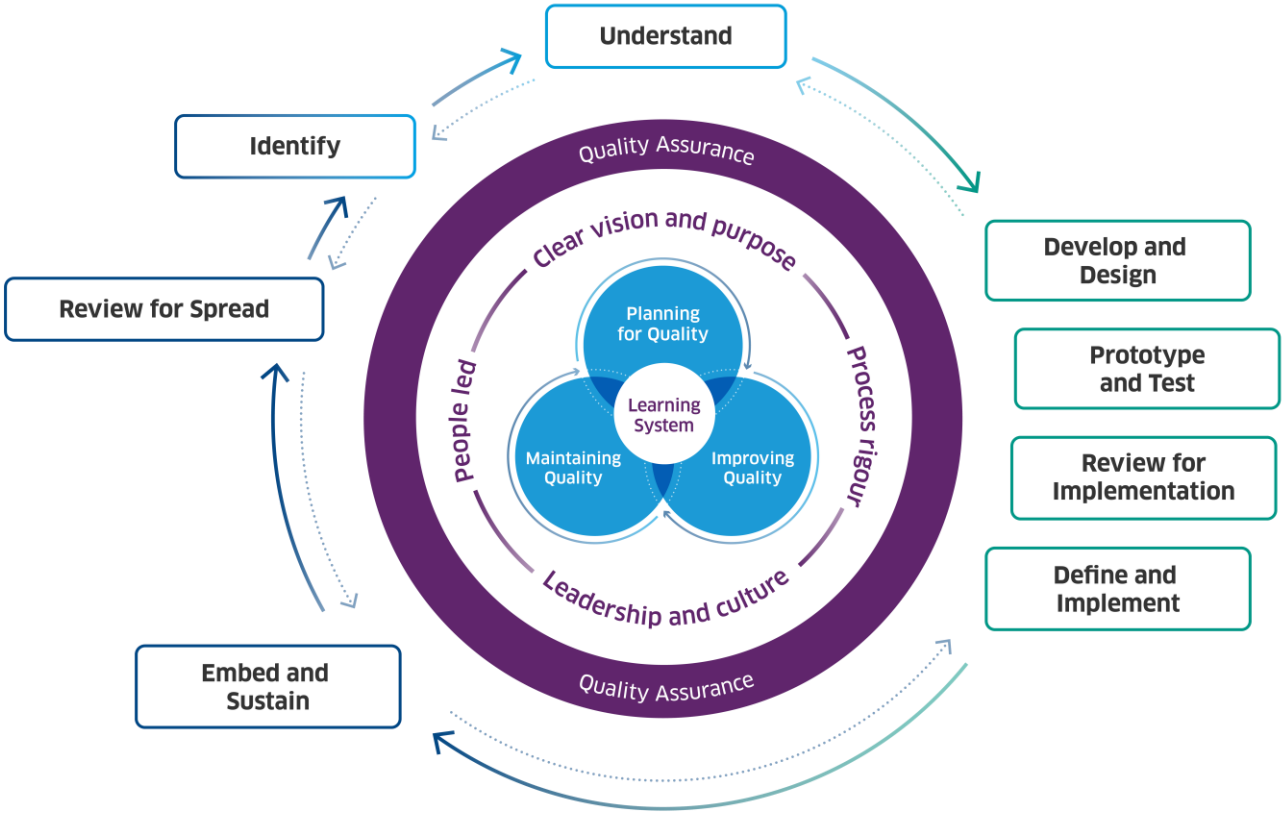
Mental Health across Healthcare Improvement Scotland



Introduction to the Delayed Discharge Improvement Programme



Value of a learning system



Delayed Discharges

AIM

Improve and maintain patient flow and reduce delayed discharges within mental health and learning disability inpatient units

WHY

- Unnecessary long-term hospital stays have a negative impact on people's physical and mental well being
- Consistent delays reduce access for others and increase staff burnout and clinical risk

Phase 1 Impact – NHS Grampian

46% reduction in MH/LD delays and a **70% increase in patients with a PDD**

Improved data and insight to inform decisions

Improved relationships for coordinated action

Clearer and better understood processes to improve speed of action and reduce bottlenecks

"New processes support a more focussed approach, improve sharing of information, and allow for closer scrutiny of the barriers for progressing towards discharge including the identification of clear escalation processes."

NHS Grampian – Nurse Manager

Phase 1 Impact – Older Adult Muick Ward, RCH

31% reduction in delayed discharges

59-day decrease in average length of stay

46% increase in standard discharges without delay (6 months post-intervention)

- Discharge planning is everyone's responsibility
- Ward and community staff training on effective discharge planning and communication
- New standard operating procedure for discharge planning
- A named nurse allocated to each person on the ward

Key Learning

- Early discharge planning is essential
- Good communication underpins success
- System-wide collaboration is essential
- Escalation pathways matter
- Patient, family and carer voice must be central
- QI methodologies

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Delayed Discharge and Patient Flow Good Practice - Overview

Aim	Primary Drivers	Secondary Drivers	Good Practice Change Ideas
To improve and maintain Patient Flow and reduce Delayed Discharge	People	In-patient, community, social work, housing, legal, providers, patient and families	Senior Executive organisational oversight and empowerment
			Dedicated senior inpatient posts or areas of responsibility for flow and discharge coordination
			Dedicated responsibility for resettlement in social work/housing within HSCP
			Legal and adults with incapacity input
	Communication	Consistent, transparent, timely	Weekly delayed discharge/DOTC Huddles
			Regular structured deep focused dives in complex cases (or themes) with routes to escalation
			Daily delayed discharge discussion with multi-disciplinary team at ward level
	Process and planning	Person centred, robust SOPs, accountable practice	Early planning for discharge – e.g., identified reason for admission, planned date of discharge, multi-disciplinary assessments, supported passes, post dx follow up
			Early identification of barriers to discharge, complex needs or circumstances
			Coordinated approach between in-patient, CMHT, IHTT/crisis teams, HSCP, providers and patient and families
	Data	Daily updates, weekly review, monthly audit	Supporting local governance and contributing to local and national audit activity
			Identifying areas for further improvement
			Highlights system strengths and weaknesses

Delayed Discharge Phase 1 outputs

- NHS Grampian Improvement Methodology Report - Reducing Delayed Discharge in Mental Health and Learning Disabilities
- NHS Grampian Summary Report – Reducing Delayed Discharge in Mental Health and Learning Disabilities
- Delayed Discharge and Patient Flow Good Practice Overview

Click the links above to access the resources.

Microsoft Teams

Call with Clare Hammond (NHS Healthcare Improvement Scotland)

2025-12-12 14:11 UTC

Recorded by
Robert Corrigan (NHS Healthcare Improvement Scotland)

Healthcare Improvement Scotland

Sharing good practice from NHS Grampian – a clinician's experience

Claire Smith (Lead Nurse, Mental Health and Learning Disabilities Inpatient and Specialist Services and CAMHS, NHS Grampian)

Kelly Evans (Senior Charge Nurse, NHS Grampian)

NHS SCOTLAND

Context

- Hosted service based at **Royal Cornhill Hospital (RCH), Aberdeen**

- Provides MHLD inpatient beds for:
  - **Aberdeen City, Aberdeenshire, Moray, Orkney, Shetland**

- Current capacity:
  - **230 beds across 17 inpatient wards**
  - Includes **15 surge beds**

- High levels of **occupancy and detentions**

- Multiple patient pathways:
  - **Adult Mental Health (AMH), Older Adults (OA), Rehabilitation, Forensic, Learning Disability etc.**
- 8 specialist outpatient teams
- **CMHTs are not part of this service** – they sit within HSCPs

Challenges

Systemic Barriers:
- Social care assessments often delayed due to capacity and funding constraints.
- Limited specialist placements and property adaptation delays create bottlenecks.
- Funding approval processes for private or complex placements can be slow.

Legal and Procedural Issues:
- Adults with Incapacity (AWI) guardianship processes and MAPPA requirements prolong discharge timelines.
- Cross-border transfers complicated by unclear protocols and bed availability.

Operational Pressures:
- High occupancy rates (>95%) across mental health wards leave little surge capacity.
- Lack of interim beds and community placements exacerbates delays.
- Pending closure of rehabilitation pathways (e.g., Polmuir Road) adds strain.

Communication and Engagement Gaps:
- CMHT non-attendance at MDT meetings despite efforts to improve accessibility via Teams.
- Inconsistent collaboration between inpatient and community teams.
- Digital access issues for social workers and MHOs to Trakcare hinder timely updates.

Cultural and Process Challenges:
- Staff frustration when delays feel outside their control.
- Need for stronger escalation pathways and clearer accountability.

Impact

Quantitative Results:

- Royal Cornhill Hospital achieved a **46% reduction in delayed discharges** and a **70% increase in patients with Planned Discharge Dates (PDD)**.

- Muick Ward pilot:
  - Average length of stay reduced from **101 days to 42 days**.
  - Delayed discharge days dropped from **349 to 61**.
  - 20 discharges achieved in a six-week period through proactive engagement.
  - Readmissions decreased post-intervention.

Qualitative Outcomes:

- Staff reported improved confidence, morale, and clarity in discharge planning.
- Enhanced patient and family involvement in planning, reducing anxiety and mistrust.
- Improved transparency in discharge planning and decision-making.
- Stronger leadership and governance, with clearer accountability for discharge processes.
- Enhanced MDT working, ensuring all disciplines contribute to timely and safe discharge.
- Better collaboration with CMHTs and social work, enabling earlier engagement and smoother transitions for complex cases.

Sustainability and Next Steps

Monitoring, Governance and Assurance:

- Strengthen data oversight for DD/DTOC and PDD compliance through regular audits and reporting.
- Adding a RAG status to the DD/DTOC meeting to prioritise cases and improve oversight.
- Ensure accurate capture of all delayed transfer of care data.
- Monitor key data such as length of stay and time of discharge.

Roll-out of Early Planning for Discharge SOP:

- Expand SOP implementation to all inpatient areas, building on Muick Ward pilot.

Culture Change:

- Embed discharge planning as a shared responsibility across all disciplines from pre-admission onward.
- Promote person-centred care and proactive engagement with patients and families.

Focus on Complex Patients:

- Develop processes to identify and address complex cases not yet on DD/DTOC lists.
- Introduce length of stay as a trigger point for escalation meetings to prevent delays.

Digital and Process Improvements:

- Resolve Trakcare access issues for social workers and MHOs.
- Standardise escalation pathways and meeting structures across wards.

Reflections

Collaboration Matters

- Working with HIS gave us structure, tools, and confidence to drive change

Culture Shift

- Discharge planning is now proactive and shared across disciplines, starting from admission

Impact Beyond Numbers

- Improved staff morale
- Better patient and family involvement
- Stronger integration with social care

Sustainability

- Processes embedded into daily practice and governance to maintain momentum

Looking Ahead

- Committed to spreading early discharge planning across all inpatient areas
- Tackling systemic barriers to sustain improvement

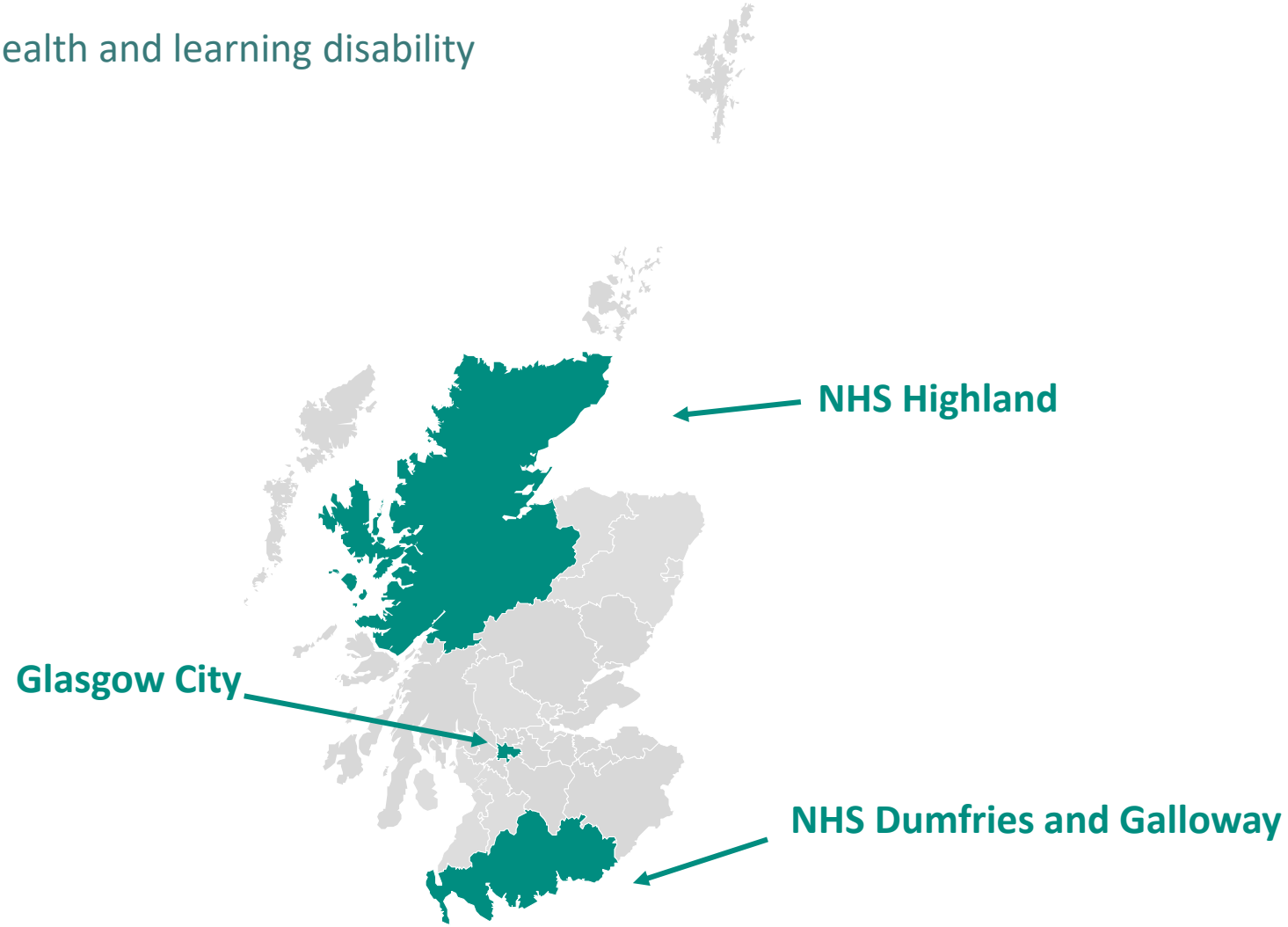
Phase 2 - Our Approach

Local improvement support

Change package from learning

Learning System

Mental health and learning disability



Phase 2 Engagement – Initial Insights

LOCAL BARRIERS TO DISCHARGE

- Admissions that could be avoided
- ‘One Size Fits All’ solutions to discharge planning
- Diverse definitions of ‘delayed’
- Rigour in discharge planning process
- Increased acuity in presentations
- Early action on complex need
- Increasing family and carer involvement in discharge
- Rurality challenges for small specialist teams

Phase 2 Engagement – Initial Insights

NATIONAL CHALLENGES

- Workforce capacity
- Availability of suitable packages of community care
- Financial landscape
- Increase in under 65’s requiring complex care

Phase 2 – Areas for Local Action

Open discussion and Q&A

Feedback

Please click this link

or the one in the chat box.

Alternatively, you can scan the QR code

The Delayed Discharge Improvement Programme: Learning System Launch

Next steps

The Delayed Discharge Improvement Programme - mailchimp mailing list consent

Use this link to sign up to our mailing list to ensure you receive all communication around future events for the delayed discharge improvement programme, including how to register.

Alternatively, you can scan the QR code above or press the link in the chat

Keep in touch

Twitter: @online_his

Email: his.transformationalchangementalhealth@nhs.scot

Web: healthcareimprovementscotland.scot