

The Delayed Discharge Improvement Programme: Initiating Improvement in Mental Health and Learning Disabilities Q&A

Q: If 13ZA was not suitable and no guardianship in place for someone that lacks capacity, what legal framework was used for your involvement?

A: The Adults with Incapacity (Scotland) Act 2000 would apply, ensuring that any intervention benefits the person, takes account of their wishes, involves relevant others, and restrict the person's freedom as little as possible.

Before a 13ZA outcome is established, a decision-making meeting should take place involving the Mental Health Officer, social work, the wider multidisciplinary team (MDT), and family or named contacts. This ensures a robust, well-documented, and rights-based process.

Where 13ZA is not suitable and no guardianship is in place, the MDT must agree on the proposed plan, and - if the individual retains capacity for the specific decision - the person must consent to the service being offered.

In this context, supporting someone to return home can provide significant benefits. Prolonged hospital stays increase the risk of loss of independence, greater reliance on staff, hospital-acquired infections, and delirium, all of which can negatively impact long-term outcomes. The Scottish Government's guidance on delayed discharge emphasises the importance of avoiding unnecessary hospitalisation and promoting supported decision-making wherever possible.

Q: Is there any Red Cross model to support community patients?

A: The models presented - Discharge to Assess (D2A), Support at Home (regulated), and the High Intensity Use Programme - typically receive referrals from acute settings, but the support is delivered to people in their own homes and communities. A core purpose of these models is to enable timely, safe discharges and prevent avoidable admissions by ensuring people have the right support and care in their home and local community.

Our teams can also accept referrals from community teams where agreed. For example, within the D2A model, we can help prevent avoidable admissions by providing short-term intervention and putting an appropriate package of care in place.

In addition to the models presented, we provide a wide range of social prescribing services. These services focus on building relationships with people - typically referred by primary care or self-referring - and connecting them to activities, groups, and services in their community to meet practical, social, and emotional needs.

These services include:

- **Holistic needs assessments and frailty support**, delivered through home visits and partnerships with GP practices.
- **Local area coordination**, linking people into community activities and strengthening local support networks.
- **Support for unpaid carers**, including assessments, goal-setting, and referrals, alongside a specialist dementia carers service.
- **Community led support**, delivered through local 'Hubs' in partnership with the Local Authority, offering signposting, practical assistance, and support with applications.

Q: Do you know if this is a service that NHS Ayrshire and Arran provide within elderly mental health and if so, how the referral process could be found?

A: Across NHS Ayrshire and Arran, we have a *Home from Hospital* service, which supports vulnerable adults, with priority given to older people over 65 years of age who do not require admission to hospital, from Accident and Emergency Departments and safely transporting them home, or vulnerable adults who are ready to be discharged.

Once home, the team assists the vulnerable adult into their home and helps them settle, ensuring their basic needs are met (with the exception of personal care and medication). The team also provides follow-up support to offer any additional short-term practical assistance for up to 12 weeks.

Follow-on support provided includes: shopping, income maximisation, wellbeing and welfare calls, liaison with Occupational Therapists and Social Workers, and signposting to third-sector organisations.

The service operates out of University Hospital Crosshouse and University Hospital Ayr, running 7 days per week. While the service does not specialise in or focus on elderly mental health, it does support vulnerable older adults.

This referral pathway is largely co-ordinated by discharge teams in the hospitals.

Q: Does this service have any experience/data with Mental health patients?

A: For our High Intensity Use services, the model supports individuals with mental health needs, which is a key focus of the service. It can also work with psychiatric liaison teams or accept referrals related to mental health admissions. However, the service does not support patients who are at immediate risk to themselves or others and who require specialist mental health intervention.

In 2024, our High Intensity Use service supported 1,058 new clients, resulting in a 43% reduction in A&E attendances, a 59% reduction in hospital admissions, and a 42% reduction

in ambulance conveyances. These figures are detailed in the presentation slides, and we are happy to share any further data.

For our D2A and Support at Home (regulated) models, we currently do not support any specific mental health wards or hospitals. However, we do support individuals with complex needs, which can include mental health. Our service also supports people who are subject to Adults with Incapacity (AWI) and those who are deemed not to have capacity. Case studies demonstrating this support, can be found in the presentation slides. We are happy to discuss and provide more information if helpful, please contact us at louisesinclair@redcross.org.uk