Healthcare Improvement Scotland

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

National Learning System

24 February 2026

Leading quality health and care for Scotland

NHS SCOTLAND

Agenda

Time	Topic	Lead
2pm	Welcome and introductions	Gordon Hay (Senior Improvement Advisor, Healthcare Improvement Scotland)
2.15pm	Overview of Mental Health work at Healthcare Improvement Scotland	Rachel King (Unit Head, Transformational Change and Mental Health, Healthcare Improvement Scotland)
2.20pm	Discharge to Assess Model - Overview - Opportunities in mental health and learning disabilities - Learning from adults with incapacity in Glasgow City	Louise Sinclair (Business Lead, Red Cross)
2.45pm	Q&A	Gordon Hay
2.55pm	Learning from Phase 2 improvement work - National level - Local level	Gordon Hay Rob Corrigan (Improvement Advisor, Healthcare Improvement Scotland) Helene Morse (Hospital Manager, New Craigs, NHS Highland) Claire Gabriel (Senior Charge Nurse, Midpark Hospital, NHS Dumfries and Galloway)
3.15pm	Q&A	Gordon Hay
3.25pm	Next steps and suggestions for future topics for learning system	
3.30pm	Closing remarks	

Healthcare Improvement Scotland

Overview of Mental Health Work at Healthcare Improvement Scotland

Rachel King (Unit Head, Transformational Change Mental Health, Healthcare Improvement Scotland)

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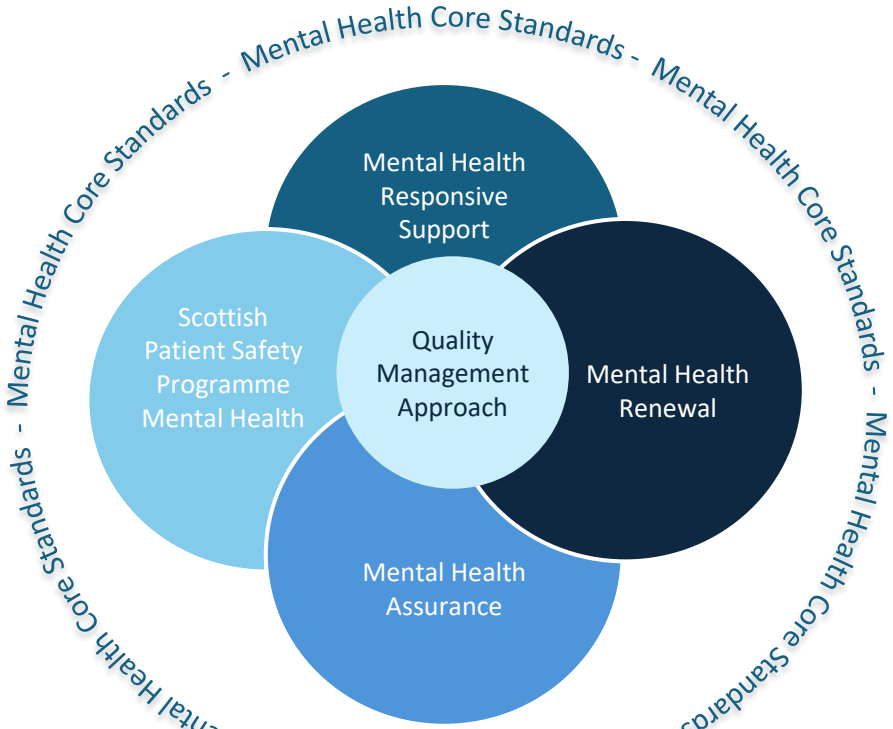
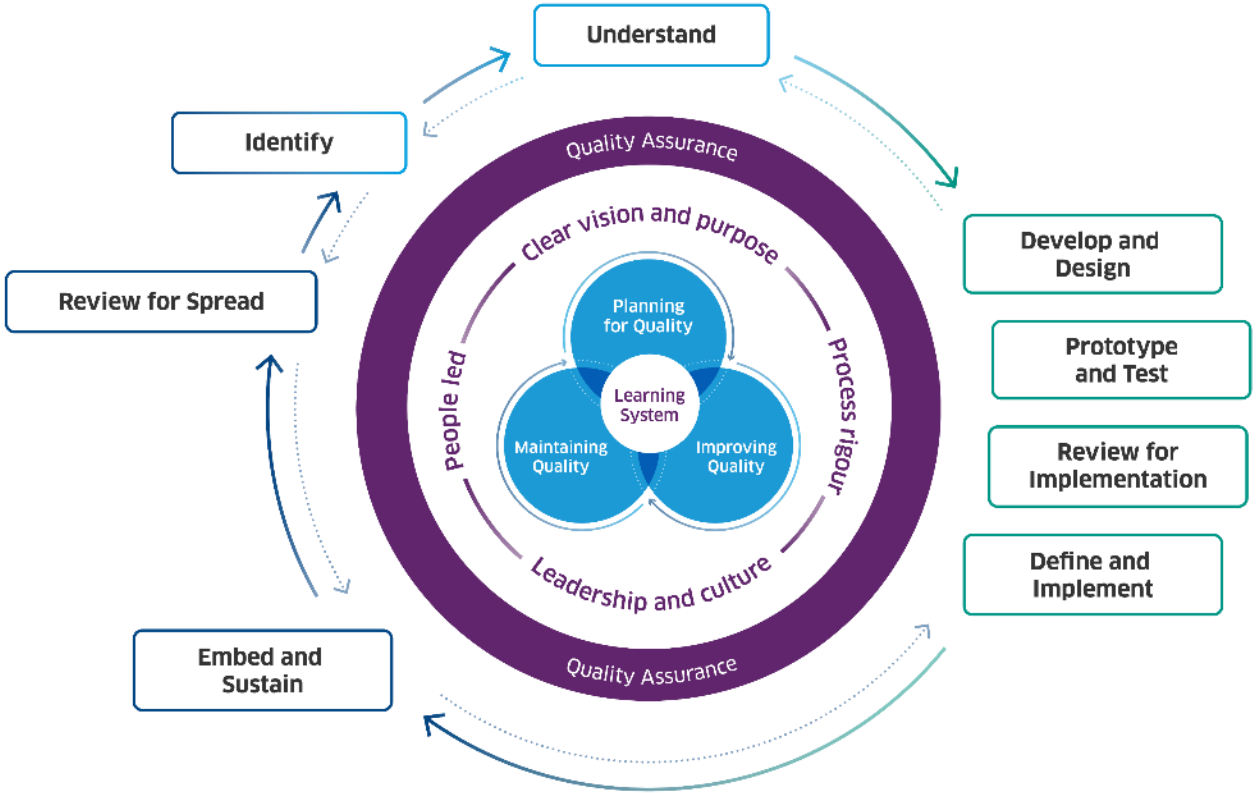
Mental Health Portfolio



Quality Management System



Healthcare Improvement Scotland

Discharge to Assess Model

Louise Sinclair, Business Lead, Red Cross

NHS SCOTLAND

BritishRedCross

Health & Care Services

Scotland 2026

The power of kindness

Introduction

The **British Red Cross (BRC)** has been **supporting** health and social care systems since the NHS was established.

We are **trusted** by the **people we support** and organisations we work with. We have a **strong track record**, a national infrastructure, combined with our responsiveness and local flexibility to ensure the **highest quality services**.

We are focussed on health equity by **improving access to care** and **support** for those experiencing the greatest barriers to improved health and wellbeing.

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Discharge to Assess (D2A)

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Discharge to Assess

- Service enabling people to leave hospital as soon as they are clinically able.
- Continuous assessment in their home over the 21-day period.
- Person-centred care and personalised support.
- Short-term model - typically up to 21- 28 days, with 24-hour wrap around care where required.
- Registered service – under Care Inspectorate.

Core objectives

Utilising technology and digital solutions, to help people live safely at home and be better connected

Reduction in hospital bed days, preventing people being delayed in hospital by facilitating discharges, including provision of end-of-life care

Reducing the reliance on care homes, people receive the right care, in the right place at the right time

Building up independence of the supported person, contributing to maintaining more people at home than other settings due to an enablement approach

Reduce level of care packages, undertaking assessment in a person's home environment, better analysis of needs and packages can be reviewed and changed as required

Supporting carers, supporting families so they don't become overwhelmed, and people are better connected with social support networks

Reduce hospital admissions, through close collaboration with urgent care services

The model

Activities undertaken by the service include:

- Assessment and support planning
- Personal care
- Medication administration
- Support with daily living activities
- Signposting / referrals to other community services

Direct support to Hospital Discharge Teams

The service can provide a senior practitioner to work alongside the hospital discharge teams Monday to Friday (09:00 to 17:00) to reduce delays in information sharing.

They will challenge current practice and suggest alternatives where possible (e.g. personal care assessments / digital support solutions / telephone welfare checks etc).

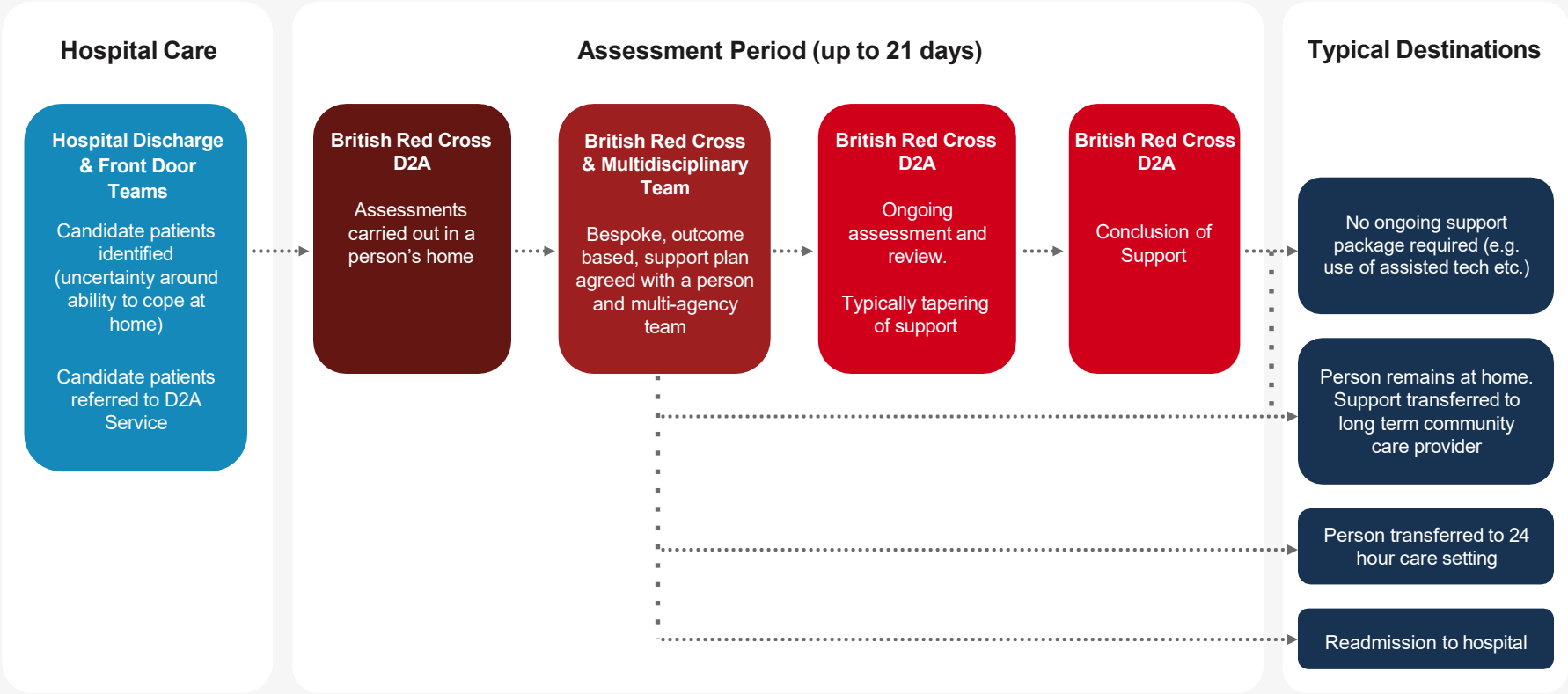
Supporting Front Door Teams

The model can also accept referrals from front door teams, helping reduce admissions and relieving pressure on the healthcare system.


Photo © Daniel Mellor/BRC

The model

The Discharge to Assess (D2A) model is adapted to align with each area's needs and pathways.



Dundee D2A

Dundee HSCP D2A Test of Change (Phase 1) ran between April 2023 and July 2024.

Based out of Ninewells Hospital in Dundee. The team work as partners with Dundee's Discharge Team.

The D2A service was born based on the success of the previous Red Cross Assessment service in Dundee.

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Impact

Our **Discharge to Assess tests of change** focus on people initially assessed in hospital as requiring a care home placement or uncertainty about their ability to live at home and **our service offers an alternative option**.

75%

of the people supported **remained at home**

Only

6%

of the people we supported **required to go into residential care**

36%

of the people remaining at home, required **no further package of care**

These impacts were achieved from Dundee test of change April 2023 - July 2024 with 140 people supported.

Phase 2

In light of an emerging frailty model and opening of another Acute Medicine for the Elderly (AME) unit, Phase 2 of the service was launched.

Phase 2, moved away from Dundee Enhanced Care at Home Team (DECAHT) and instead would support the front door.

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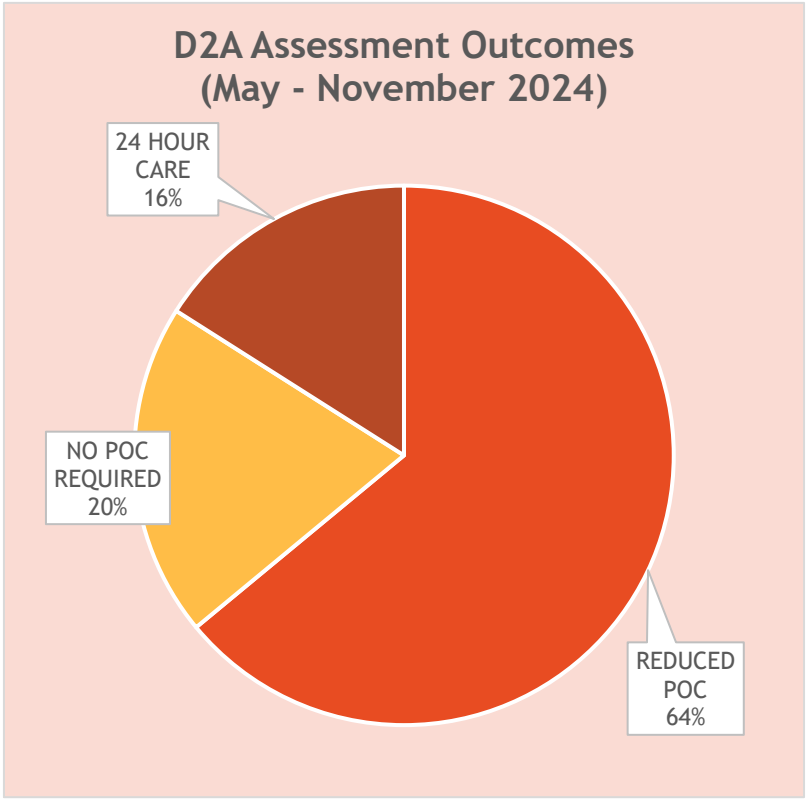
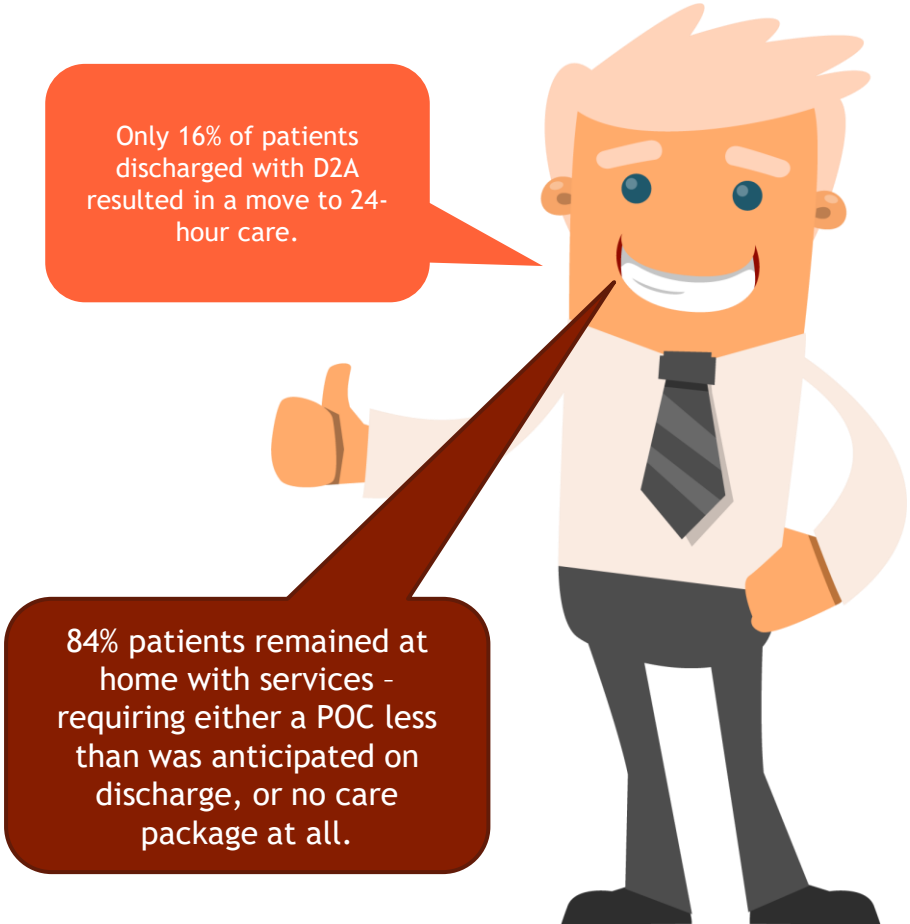
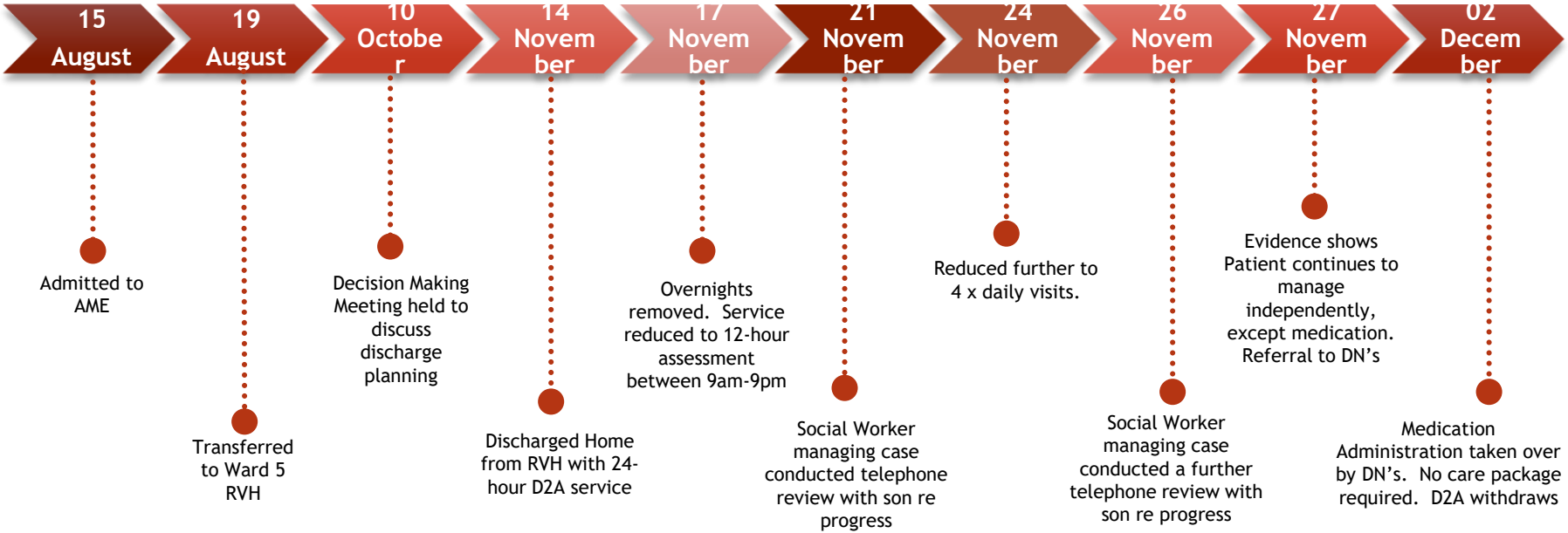
D2A Assessment Outcomes





PATIENT CASE STUDY

Presentation	• AWI in situ due to post-stroke confusion. • MDT felt that Patient D was unable to return to own property due to risk on stairs. • MDT recommended a move to 24-hour care or very sheltered housing on discharge. • Sons were pursuing private Guardianship order prior to admission • 13za could not be utilised as patient was clear about their wish to return home. • Patient was offered opportunity to go home with D2A as the alternative was to remain in hospital for the duration of the Guardianship process. Family in agreement as they were against the idea of 24 hour care.
Length of time on Service	18 days
Outcome of Assessment	Remain at home with no POC – only requires support from DN's for medication



Fife H2A

Home to Assess (H2A) is based on the Dundee D2A model.

A test of change began in May 2024.

The service works alongside the Discharge Teams at Victoria Hospital and Queen Margaret Hospital.

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Impact

Before the H2A service, the majority of people who were on an assessment bed in a care home **did not return home** and **moved to a permanent care home placement.**

The H2A service offers an alternative option and is supporting people to remain at home.

82%

of the people supported **remained at home**

7%

of the people we supported required **to go into residential care**

7%

of the people we supported required **to go back into hospital**

These impacts were achieved from Fife's test of change May 2024 to May 2025.

A's Journey Home

A following a 2-year hospital stay due to a fall and encephalitis, was **discharged** into the D2A service **under guardianship,** initially lacking capacity.

Intervention

- **Supported home safety adaptations** (oven disconnection, fire safety check, installing handrails, setting up a community alarm, bin collection).
- **Provided daily meals and coordinated medication** support with GP and pharmacy.
- **Introduced housing support** for shopping and outings once settled.
- **Gradually reduced support** over time using an **enablement approach.**

Impact

- A **made significant progress** and was **reassessed as having regained capacity.**
- Although extended support was required (27 days), the outcome was extremely positive — **highlighting the impact of tailored, person-centred care.**

Outcome

- Discharged to the service in October 2024
- **Capacity regained following intervention**
- **Remains at home** with no formal care package; only housing support required

Cost Comparison

- D2A service (enhanced average for 27 days): **£16,038**
- Equivalent care home admission (annual): **£45,990***
- Equivalent hospital care (annual)**: £225,570****

Even when factoring in housing support, the D2A service offers substantial savings versus the realistic alternatives of extended hospital stay or residential care.

*Audit Scotland, Delayed Discharges Report January 2026, £126 per day average for a publicly funded residential care home placement

**Audit Scotland, Delayed Discharges Report January 2026, estimated average daily net cost of a hospital bed in Scotland of £618 based on 2023 / 2024 costs.

The difference we made

*"**It has been life changing** and allowed my cousin the ability to go home from hospital."*

Family of person supported

*"I feel the staff have **improved my quality of life.**"*

Person supported

*"Everything has been fantastic, the **help, care and assistance has been second to none**."*

Person supported

*"This has been positive in every way, because not only has it provided **better outcomes for people, it's enabled us to slash our care home budget.**"*

Dundee HSCP Representative

*"**I would be delighted to recommend the Red Cross Discharge to Assess** to anybody within their own health board or partnership."*

Fife HSCP Representative

Evaluation and review process

Dynamic process of review for each person being supported

Ongoing conversations and monitoring with the person to adjust levels of support required

Progress updates reported at weekly interdisciplinary meetings

Evaluation reports at 6 month and 1-year intervals to review statistical impacts, return on investment, case studies and feedback

Monthly review with the Commissioner in terms of outcomes and value

Active use of goals and quality evidence to shape the service, ensuring individualised support meets the need

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Support at Home

The power of kindness

Support at Home

- A partnership between the British Red Cross and Glasgow City HSCP designed to reduce hospital discharge delays.
- Focuses on delays relating to Adults with Incapacity (AWI).
- Delivers up to six weeks of personalised Support at Home, helping individuals transition safely back into the community.
- Service commenced October 2025.

ACTIVITY	DESCRIPTION
Re-settlement & Safeguarding	Ensuring a safe home environment and supporting the settlement after discharge.
Housing Support	Tenancy support, budgeting and managing finances, support with managing appointments, and light domestic and practical tasks like doing the dishes, laundry, and hoovering.
Shopping Support	Assisted shopping with or on behalf of the service user.
Emotional Support	Active listening, empathy, signposting, emotional connection, and support.
Socialisation	Community engagement and family reconnection.
Assistive Technology	Potential support for the use of alarms, sensors, and monitoring tools to aid daily living.
Personal Care – ***If need identified outside formal care and support package.***	Bathing, dressing, toileting, and hygiene support.
Medication Support – ***If need identified outside formal care and support package***	Prompting, assisting, and administering medications.

Case Study

An elderly woman living with dementia and her registered blind husband were supported primarily by their adult son, who was experiencing significant carer stress.

Following a fall in October 2025 and subsequent hospital admission, she was referred to our service to enable a safe and timely discharge home and to help maximise her independence.

Intervention

- **Resettlement and ensuring a safe home** environment post discharge
- **Socialisation** at home and in the community, as she is highly sociable.
- **Meal preparation and shopping support** to relieve pressure on her son.
- **Referrals for long-term support** and functional assessments.
- **General household tasks** such as cleaning and tidying, which neither she nor her husband could maintain.

Challenges

- **Dementia significantly affected ability to accept support**— previous trauma and distress led to challenges with multiple staff members.
- To reduce anxiety, a single worker model was agreed

Outcomes Delivered

- **Successfully resettled at home** with a six-week support plan.
- **Consistent twice-weekly visits** (7 hours a day) from the same Support Worker, improving trust and engagement.
- **Regular support** with shopping, meals, cleaning, and community activity, reducing family pressure.
- **Referrals completed** (meal service, OT, Continence Team), securing appropriate ongoing supports.
- Emotional and practical support provided to her son, helping **reduce carer strain** and signposting to carer support services.
- **The couple remain safely at home with enhanced supports in place.**

"Your Team was incredible; we don't know what we would have done without him..."

Service User's Husband

Service Feedback

A Community Team Leader from Adult Social Work shared how **transformative the team's support has been for a service user.**

They reported a significant positive change:

- The service user's home is now clean and well-maintained
- Their clothes are fresh and clean
- Their overall presentation has improved, with them appearing noticeably happier, healthier, and more confident
- The team's support has clearly enhanced daily life and wellbeing

As a result of this progress, laundry support is now being added to their care package to help sustain these improvements.

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High Intensity Use Programme

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HIU Programme

An assertive outreach programme for people who access urgent and emergency care services regularly because they are falling through gaps in the health and social care system.

The Challenge

- Urgent and Emergency Care pressures
- Health inequalities
- Inclusion Health
- Prevention

The Service

A holistic and strength-based, one-to-one coaching approach that can be tailored to support any part of the health and care system.

The service has traditionally supported people who access emergency departments more than expected and has expanded to successfully support Mental Health pathways, Ambulance Trusts, Adult Social Care and Criminal Justice.

A proven solution that reduces activity as a by-product of helping someone to live a better life.

The Impact

- **Improved health and wellbeing**
- **Increased activation** leads to improved **confidence and sense of control**
- Increased **resilience**
- Reduced **loneliness**
- Reduction in **Emergency Department attends**
- Reduction in **Emergency Admissions**
- Reduction in **Ambulance Conveys**
- Strong **ROI** and **Social Value** metrics

Service principles for high intensity use programme

Data led patient identification

- ED attendance
- Emergency Admissions
- Psychiatric Liaison referral or MH admissions
- Ambulance calls and conveys
- GP visits

Programme delivery approach

- 1:1 casework
- De-medicalised and de-criminalised
- Supported self-management
- Health coaching

Holistic person-centred support

- Improve access to services
- Care co-ordinate
- Identify unmet social needs
- Reconnect individuals with friends, purpose and community

Unmet social needs can exacerbate wellbeing and lead to frequent use of emergency services.

Examples:

- People who are having a tough time and unable to cope
- Grief / loss / rejection / childhood trauma
- Unemployment / lack of purpose
- Loneliness and social isolation – lack of connection
- Multiple long term conditions
- People struggling with their mental health
- Homelessness & housing issues – nowhere that's 'home'
- Addiction
- Language barriers
- Digital exclusion

HIU Case Study: Max

1 Ambulance conveyance in previous 3 months

9 A&E attendances in previous 12 months,
6 of which in previous 3 months

Gall Stones causing uptick in A&E attendances,
with potential to escalate

3 non-elective admissions in previous 12 months,
2 of which in previous 3 months

Comes across as gregarious and outgoing

Debt of £7.5k to Energy Company

Bereavement of losing daughter

Spending £80 on public transport per
appointment

Worry of debt means not eating,
drinking or sleeping properly

Hard worker who reliably keeps
appointments and commitments

Landlord refusing to fix broken radiators, toilet,
old carpets and spreading mould.

High Alcohol Consumption

Self-starter with the
confidence to address difficulties

No heating in flat, relies on costly
electric heater for single room

Resilient with high level
of health activation

Always bounce-back attitude

State Pension cannot cover daily
cost of living and pay off debt

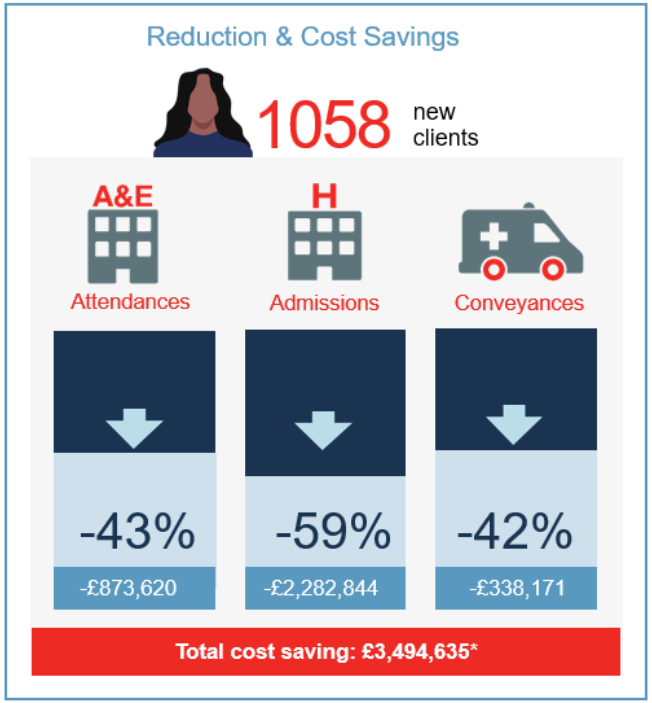
Artistic drive and quality of
painting suffering due to worry

Charismatic storyteller ready
to share his experience to help others

Outgoing personality disguises
difficulties in private life

Impact Data

The figures demonstrate the impact **HIU services** had with the new clients accepted for support during **January - December 2024**.



*Does not include other UEC activity, such as Liaison Psychiatry or 999 calls.

Total cost savings of

£3,494,635

HIU Programme 2024
Return On Investment

240%

Impact Data

Jan 24 - Dec 24

A closer look at the cumulative 2024 numbers

	A&E Attendances	H Admissions	Conveyances
Comparable time frame **pre** support	4816	1542	2256
Comparable time frame **post** support	2726	639	1315
Total reduction	2090	903	941
% Variance	-43%	-59%	-42%

				Total
Comparable time frame **pre** support	£2,013,088	£3,898,875	£796,126	£6,708,089
Comparable time frame **post** support	£1,139,468	£1,616,031	£457,955	£3,213,454
Total savings	£873,620	£2,282,844	£338,171	**£3,494,635**

Professionals feedback

"I know 'Jack' really ***appreciates everything you have done for him.***

You have managed to ***develop*** *and* ***maintain a relationship*** *with him;* ***which is so important in helping him to understand he can trust people, especially professionals – thank you!!"***

Social Worker

"The service is unique, and ***it meets needs of patients that present in A&E in a manner that supports their mental health needs.***

I would not hesitate to recommend this service to patients and other service users.

I think the service should be scaled up as it is an important part of mental health service delivery."

Senior Psychiatric Liaison Nurse

Contact us:

Louise Sinclair
Senior Business Development Manager – Scotland

louisesinclair@redcross.org.uk

BritishRedCross

Open discussion and Q&A

Healthcare Improvement Scotland

Learning from Phase 2 Improvement Work

Gordon Hay (Senior Improvement Advisor, Responsive Support, Healthcare Improvement Scotland)

Robert Corrigan (Improvement Advisor, Responsive Support, Healthcare Improvement Scotland)

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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 2 improvement work

- Building on learning from Phase 1 of the programme where tests of change were introduced in NHS Grampian and NHS Ayrshire & Arran as part of the national mission to reduce delayed discharges from MH/LD inpatient facilities

- HIS is now working with three new pilot areas to implement improvements, adapted to local needs and context

- Through 2025-26, HIS will provide coaching support to these areas to:
  - Understand key causes of delays
  - Use data to drive improvements
  - Engage local teams
  - Identify and implement improvement actions

New Craigs Hospital, NHS Highland

Areas identified for improvement:

- Working with staff to develop tests of change to support patient flow on their Dementia Assessment Unit (Ruthven Ward
- Processes associated with earlier discharge planning
- Exploring barriers to discharge for Hospital Based Complex Clinical Care patients (HBCCC)

Midpark Hospital, NHS Dumfries & Galloway

Areas identified for improvement:

- Weekly discharge huddle - to introduce a number of evidence-based changes to the delayed discharge weekly meeting and to explore case escalation processes
- Early discharge planning on their older adult ward (Glencairn Ward) – dynamic admission checklists, formulation planning meeting, SOPs for admission and discharge

Glasgow City HSCP

- Work with GC will initially consist of an extended discovery phase to gain a deep understanding of processes, pressures, and stakeholders

- In person process mapping workshops are planned and attendance at site-specific DD meetings to identify opportunities for improvement

- Providing support to a PDD improvement project at Leverndale Hospital

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Learning from Phase 2 improvement work at a local level – NHS Highland

Helene Morse (Hospital Manager, New Craigs, NHS Highland)

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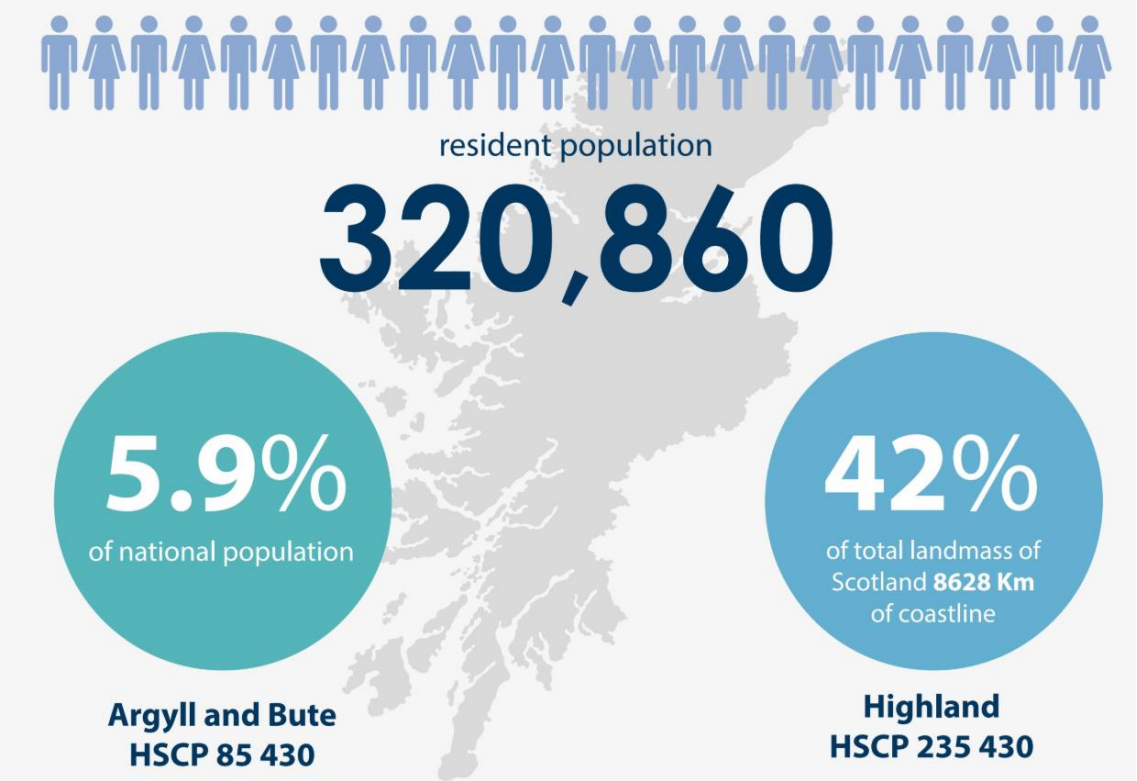
NHS Highland

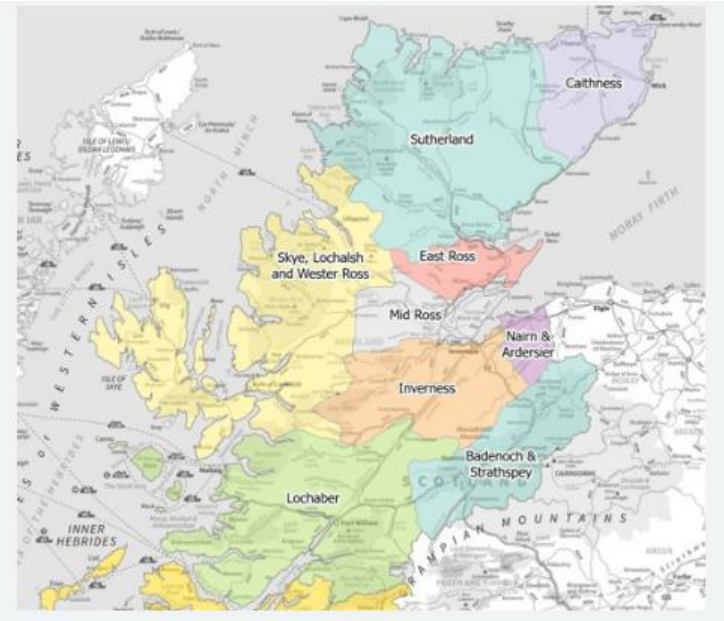
Mental Health and Learning Disability – Delayed Discharges

A brief introduction the NHS Highland

NHS Highland



Highland Health and Social Care Partnership



New Craigs Hospital

New Craigs Hospital

- 10 bedded Intensive Psychiatric Care Unit
- 24 Bedded Adult Acute Admission ward
- 14 bedded Step-down Acute Ward
- 12 bedded Older adult Acute Ward
- 24 bedded Dementia Care Unit
- 8 Bedded High Dependency Rehab Ward
- 6 Bedded Learning Disability Assessment and Treatment Unit
- Capacity for 2 surge beds
- Total beds – 98 + 2 surge
- All single rooms with en-suite bathrooms.

Top Admission Diagnosis from January 2023 to December 2025

Mental and behavioural disorders due to use of alcohol. Dependence syndrome	18.38%
Schizophrenia	10.66%
Bipolar affective disorder	9.24%
Schizoaffective disorder	4.88%
Recurrent depressive disorder	3.20%
Personality disorder	3.02%
Other schizophrenia	3.02%
Acute polymorphic psychotic disorder without symptoms of schizophrenia	2.93%
Post-traumatic stress disorder	2.58%
General psychiatric examination	2.49%

Top Admission Diagnosis by Age (January 2023 to December 2025)

Age Banding	No. of Admissions	Admission Diagnosis	%Age of Admissions
18 or Under	26	Childhood Autism	23.08%
19 to 29	140	Schizophrenia	15.00%
30 to 39	230	Mental and behavioural disorders due to use of alcohol. Dependence syndrome	20.43%
40 to 49	234	Mental and behavioural disorders due to use of alcohol. Dependence syndrome	30.34%
50 to 59	238	Mental and behavioural disorders due to use of alcohol. Dependence syndrome	22.69%
60 to 64	79	Mental and behavioural disorders due to use of alcohol. Dependence syndrome	25.32%
65 to 69	52	Bipolar affective disorder	19.23%
70 to 74	48	Vascular dementia	10.42%
75 or Over	79	Vascular dementia	20.25%

Delayed Hospital Discharges

- Current DHD – 21
- Longest length of stay = 2621 days
- Shortest length of stay – 56 days
- Longest length of stay as DHD – 972 days
- Shortest length of stay as DHD – 10 days

Hospital Based Complex Continuing Care Patients

- Dementia Care – 12
- Older Adult Acute – 1
- High Dependency Rehab –1

Ruthven Ward – our Dementia Care Unit was chosen for this improvement project. 24 bedded ward with 12 HBCCC patients and 4 Delayed Hospital Discharges.

Areas for Action identified through workshops

Challenges and Reflections

- No inpatient consultant model in older adults – related difficulties in Multi-Disciplinary representation at MDT Meetings with 4 different consultants.
- Ongoing staffing and acuity pressures – concerns raised by nursing team about capacity for improvement work even though they recognise the benefit. Having the support of the HIS project team is vital for the staff team.
- Encouraging all multi-disciplinary members involvement – the benefit of this being a joint improvement journey with HIS is that staff have described a sense of being listened to across disciplines.
- The workshop participation with HIS was encouraging – staff reflections were that it was a positive process
- Process mapping of discharge continues – part of pilot project is to concentrate on the Dementia Unit.
- Staff hope to see an improvement in the patient journey through admission to discharge – improved links between inpatient team and care homes – targeted referrals – and improved communication.
- Better recognition of unmet need in patients with impaired communication; particularly around pain assessment and management.

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Learning from Phase 2 improvement work at a local level – NHS Dumfries & Galloway

Claire Gabriel (Senior Charge Nurse, Midpark Hospital, NHS Dumfries & Galloway)

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Open discussion and Q&A

Suggestions for future topics as part of the learning system

Please put any suggestions you have in the chat box or on our feedback form

Register for upcoming Good Practice Session

Good practice session: use of mental health and adults with incapacity delayed discharge data

Scottish Government would like to invite you to a good practice session focusing on use of mental health and adults with incapacity delayed discharge data on **Thursday 19 March** taking place between **1-2pm** via **MS Teams**.

This session is aimed at anyone involved in managing delayed discharges within mental health, and adults with incapacity. Colleagues working within the learning disability space are also encouraged to attend, as we are aware that there is often crossover between the three workstreams.

This is an opportunity to learn ways of becoming better acquainted with data which is available to you within your local system and nationally, as well as how to understand and approach data with confidence and curiosity.

Please click this link to register or the one in the chat box.

Feedback

Please click this link

or the one in the chat box.

Alternatively, you can scan the QR code

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

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.

Keep in touch

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