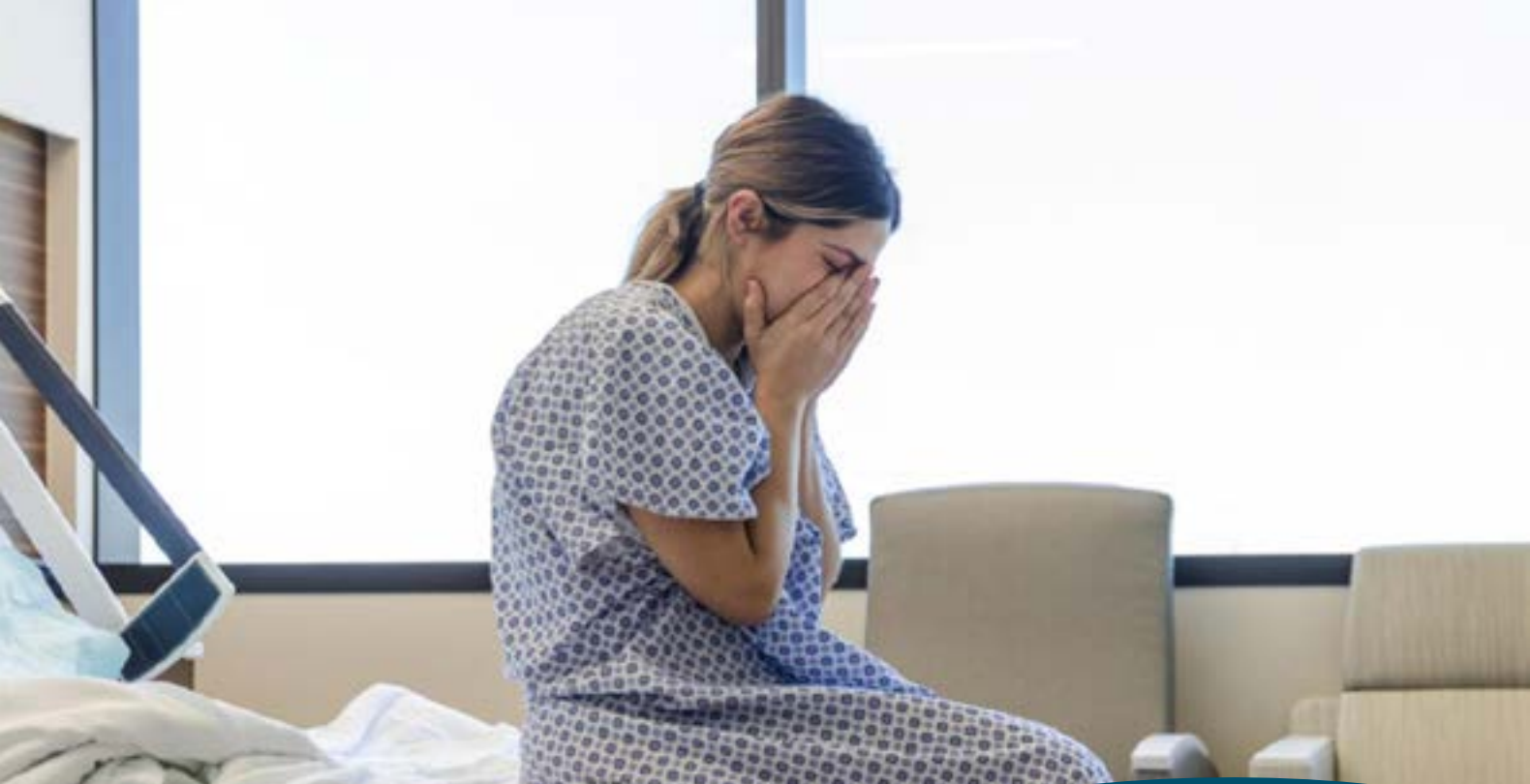

Beyond Capacity: The Systemic Impact of Delayed Mental Health Discharges

A Healthwatch Central Bedfordshire report exploring how discharge delays for mental health patients in acute hospitals affect patients, staff, and the wider healthcare system.

May 2025

healthwatch Central Bedfordshire

Content...

Introduction

Extended hospital stays for mental health patients within acute general hospitals are a growing national concern. Acute general hospitals are not designed for long-term mental health care, yet systemic pressures and service gaps are leading to prolonged stays for individuals experiencing a mental health crisis. This trend has significant implications for the healthcare system, placing strain on resources, compromising patient outcomes, and exposing frontline staff to distressing and often unsafe situations.

Several key issues underpin this problem:

- **Pressure on Acute Beds:** Mental health patients occupying beds for extended periods limit capacity for those with urgent physical health needs.
- **Inappropriate Environment:** General hospital settings are ill-equipped to provide the therapeutic support required by individuals in mental health crisis, often exacerbating their condition.
- **Staffing Strain:** General hospital staff may lack the specialist training to care for mental health patients, contributing to stress, burnout, and safety concerns.
- **Delayed Access to Specialist Care:** Delays in transferring patients to appropriate psychiatric services hinder timely treatment.
- **Poor Patient Outcomes:** Fragmented care in unsuitable settings increases the risk of deterioration in both mental and physical health.
- **Inefficient Use of Resources:** Prolonged inpatient stays in the wrong care setting are an inefficient use of healthcare resources.

Understanding the Issue: Background and Purpose

Healthwatch Central Bedfordshire (HWCB) became aware of growing concerns about the impact of delayed discharges for mental health patients within acute hospital settings.

These concerns were raised through a combination of internal discussions and direct feedback from patients, carers, and frontline staff, who highlighted the strain placed on individuals, services, and the wider hospital environment. The issue gained particular urgency in late 2024 to early 2025, when reports of prolonged stays and patient safety risks began to increase.

This review was initiated to gain a deeper and more balanced understanding of the systemic challenges from both clinical staff and patient perspectives, and to develop evidence-based recommendations that could inform practical and sustainable improvements across the local health system.

Methodology

In March 2025, Healthwatch Central Bedfordshire (HWCB) undertook focused visits to both Bedford Hospital and Luton & Dunstable University Hospital, the two sites that make up Bedfordshire Hospitals NHS Foundation Trust. The aim was to understand the impact of extended hospital stays for mental health patients and gather first-hand perspectives from frontline clinical staff across relevant departments.

Bedford Hospital operates across two main locations: the South Wing, where most services are based including the Cygnet Wing for women and children, and the North Wing. HWCB's site visit focused on three key areas within the South Wing:

- **Emergency Department (ED):** Responsible for the diagnosis and urgent treatment of acute illness and injury.
- **Acute Assessment Unit (AAU):** A rapid-assessment facility for patients with acute medical emergencies.
- **Whitbread Ward:** A 27-bed short-stay medical ward supporting patients assessed via the AAU. Staff aim for discharge or transfer within three days, although some patients remain longer due to clinical or system-related delays. The ward team includes doctors, nurses, pharmacists, therapists, advanced practitioners and administrative staff.

Luton & Dunstable University Hospital is a large single-site facility organised across four main buildings covering medicine, surgery, and women's and children's services. HWCB staff visited the following wards:

- **Emergency Department (ED):** Providing immediate care and triage for patients with urgent medical needs.
- **Emergency Assessment Unit 1 (Ward 1):** A 25-bed unit adjacent to the ED, designed to manage patients directly from emergency triage.
- **Emergency Assessment Unit 2 (Ward 4):** A mirror unit to Ward 1, also with 25 beds and a similar clinical function.
- **Ward 11:** A 33-bed short-stay ward on the third floor of the Medical Block, receiving patients from the EAUs, ED, and the Same Day Emergency Care (SDEC) unit.

Across both sites, HWCB staff spent approximately six hours conducting semi-structured interviews with clinical staff, including nurses, doctors, advanced care practitioners, and agency staff, to explore the challenges they face in supporting mental health patients admitted to general hospital settings. Interviews were conducted confidentially and responses anonymised to encourage candour and protect participants.

A total of 26 interviews were completed across the two hospital sites, involving clinical staff from a range of departments and levels of seniority. These conversations provided rich qualitative insights and helped build a comprehensive picture of the systemic pressures affecting mental health patients in acute hospital settings.

Objectives and Approach

The interviews were structured to explore the following key areas:

- The prevalence and nature of extended hospital stays for mental health patients.
- The causes and systemic challenges contributing to delays in discharge.
- The impact of prolonged hospitalisation on mental health patients, their families, hospital staff, and other patients on the wards.
- Ideas and suggestions for improving patient flow, care quality, and discharge pathways.

These objectives were developed to ensure a balanced understanding of the issue from multiple perspectives and to inform meaningful, evidence-based recommendations for local system improvement.

Findings – A Summary of Perspectives

Mental Health Patient Admissions and Length of Stay

At both Bedford Hospital and Luton & Dunstable University Hospital, staff consistently reported a frequent and regular flow of patients presenting in mental health crisis. In Bedford, Emergency Department (ED) staff noted seeing up to 15 mental health (MH) patients in a single 24-hour period, though three per day was reported as the average. Notably, the volume of Mental Health presentations increases significantly during periods of heightened stress, such as the holiday season or exam times.

In Luton, the average was reported to be slightly higher, at approximately six Mental health patients per day. Staff from both sites estimated that at any one time, between three and five Mental Health patients would typically be admitted to short-stay wards. Despite being medically stable, many of these patients remain in acute settings for extended periods, often due to delays in psychiatric assessment and a lack of appropriate mental health bed capacity.

Staff at Bedford reported Mental Health patients staying for up to two weeks, while staff at Luton indicated that stays of over four weeks, and in some cases up to three months, were not uncommon.

This prolonged presence of Mental Health patients in general wards not only contributes to capacity pressures but also places patients in environments that are often unsuitable and potentially distressing.

Delays in the discharge of Mental Health patients were attributed to several systemic and operational challenges. One of the most consistently cited issues was delayed mental health assessment, particularly for patients arriving overnight. Staff reported that patients often had to wait for extended periods, sometimes beyond 24 hours, for a Mental Health Nurse (RMN) to be allocated.

A pervasive theme was the complete lack of available psychiatric beds. As one member of staff put it, ***"There is no psychiatric bed availability"***. Another described the downstream effect of this: ***"Some patients are admitted to the ward medically fit, but awaiting a psychiatric bed, and are then exposed to infection."***

Social and environmental barriers also played a significant role. Some patients, staff explained, could not be discharged due to risks to themselves or others. ***"The patient may pose a risk to the public or their family."*** Others were homeless or did not ***"feel safe to go home,"*** creating further discharge obstacles. Delays in securing housing and care packages compounded the issue.

Patients with specific needs, such as eating disorders, were also affected by long waits for transfers to specialist units. Staff also highlighted gaps in support from Community Mental Health Teams (CMHTs), and noted a systemic disconnection between physical and mental healthcare. This fragmentation of services was summed up as a ***"disconnect and lack of integration between the two areas of healthcare, despite them being deeply interconnected."***

Information sharing was another critical barrier. Hospital staff regularly reported being ***"left lacking crucial information"*** about a patient's clinical history, known triggers, or behavioural patterns. As one RMN noted, ***"It is difficult to meet patient needs as a good background of the patient is needed, however I am unable to access any information."***

One of the most pressing observations came from a staff member who stated that many of the same patients return repeatedly because ***"they are not cared for adequately in the community."*** This revolving door creates a cycle of crisis, admission, delay, and eventual discharge without sustained recovery.

Impact on Mental Health Patients and their Families

The emotional and clinical toll on patients was profound. Long delays in accessing psychiatric care were seen to ***"intensify their suffering and delay crucial care, worsening their physical and mental health."*** Several staff members said they had ***"witnessed patients deteriorating due to their wait for specialised care."***

The acute hospital environment, noisy, clinical, and high-pressure, was described by some as ***"a deeply unsettling and overwhelming experience"*** for patients in crisis. The lack of appropriate care environments further eroded trust. ***"Many patients experience a lack of continuity, resulting in further distress and an erosion of trust,"*** one staff member explained. Another commented on how this left individuals ***"feeling abandoned and uncertain about their care."***

The risks extended beyond psychological impacts. One staff member raised concerns about the ***"close proximity of the hospital to the main road,"*** stating that this poses a real safety risk for patients who frequently abscond.

Families were not spared the emotional toll. Staff described witnessing ***"increased emotional distress"*** among family members, who often felt judged or stigmatised when visiting. The experience was described as ***"a hostile environment that further isolates them during an already difficult time."***

Impact on Hospital Staff

Every staff member interviewed described the impact of prolonged Mental Health patient stays on their own wellbeing as significant. ***"Delays in hospital discharge for mental health patients have a significant negative impact on staff's ability to perform regular duties and their personal well-being,"*** one said. Another admitted, ***"I am traumatised caring for patients who are trying to commit suicide. I have PTSD from working on Whitbread Ward."***

Incidents of violence and aggression were frequent. One staff member described being ***"punched in the face twice"*** by a patient, while another said they were ***"attacked by a male patient, who grabbed her neck and kissed her cheek."*** Others recalled being ***"shouted at, screamed at, and insulted"*** on a regular basis.

The emotional and physical toll is pushing some to breaking point. ***"I didn't want to come into work as I felt fearful of violence and intimidation,"*** said one. Another described experiencing ***"physical symptoms of stress including panic and chest pain."*** A senior nurse admitted, ***"It's too much, I can't do this every day!"***

Staff recounted disturbing incidents, including a colleague being ***"choked in a side room with an IV tube,"*** a doctor ***"chased with a knife,"*** and another staff member narrowly avoiding injury when a patient ***"picked up a chair and threw it."*** One staff member stated, ***"Some patients hate you because they feel you are not doing enough,"*** highlighting the complex emotional strain of providing care in a high-stakes, under-resourced environment.

Agency RMNs echoed concerns about continuity of care, with one stating, ***"It's better if the patient receives care from the same agency nurse... but this continuity is infrequent."*** Another reported that ***"restraint is risky in this environment,"*** and that they often had to rely on security due to a lack of training among general nursing staff.

Impact on other Patients

The presence of Mental Health patients in crisis on general wards has a tangible and troubling effect on other patients. Some patients ***"feel their needs are neglected"*** as staff divert attention to mental health crises. One nurse noted, ***"We need to spend a lot of time with mental health patients and others do get neglected."***

Patients have also expressed feeling ***"vulnerable and stressed,"*** with some requesting transfers to other wards. Staff cited multiple incidents of patients experiencing ***"difficulty sleeping and recovering from surgery or illness"*** due to noise and agitation from neighbouring Mental Health patients.

There were even cases of direct harm. One staff member recounted that ***"a cardiac patient was punched in his bed by a mental health patient."*** Others told of patients choosing to ***"discharge themselves from hospital"*** early due to the environment, putting their recovery at risk.

Summary of Key Issues

This investigation exposes the escalating pressures placed on acute hospitals due to the prolonged admission and delayed discharge of patients experiencing mental health crises. The findings confirm a deeply entrenched system failure, where the absence of timely psychiatric support, limited specialist beds, and gaps in community provision have normalised the inappropriate use of general medical wards for mental health care.

The consequences are far-reaching and affect all involved. Patients are left in unsuitable environments that exacerbate their condition, often experiencing delays that ***"intensify their suffering and delay crucial care."*** Some remain hospitalised for weeks or even months, despite being medically fit for discharge, leading to further deterioration, frustration, and a growing sense of abandonment. One staff member described witnessing ***"patients deteriorating due to their wait for specialised care,"*** while another noted, ***"many patients experience a lack of continuity, resulting in further distress and an erosion of trust."***

Hospital staff are stretched beyond their roles, caring for patients in crisis without the necessary training, support, or information. The emotional and physical toll is acute. Several staff described feeling ***"terrified,"*** with one admitting, ***"I have PTSD from working on Whitbread Ward."*** Others reported suffering physical assaults or stress-related symptoms such as panic attacks and chest pain. One senior nurse concluded, ***"It's too much — I can't do this every day."***

Meanwhile, the presence of distressed, often agitated, mental health patients has a tangible impact on other hospital patients, with disrupted recovery, anxiety, and even incidents of violence. ***"A cardiac patient was punched in his bed by a mental health patient,"*** one staff member revealed, while another reported that ***"some patients feel vulnerable and exposed and choose to discharge themselves."***

Ultimately, this report highlights a health and care system under strain, one that lacks integration between physical and mental health services, and where the absence of timely and appropriate psychiatric care is placing patients and staff at risk. Without urgent reform, these pressures will continue to compromise safety, outcomes, and trust in local care services.

Conclusion

The experiences captured through this review offer a stark and urgent call for systemic reform. The prolonged admission of mental health patients within acute general hospitals is not only clinically inappropriate, it is harmful. These patients are often left in environments that intensify their distress, delay their recovery, and deny them the specialist interventions they desperately need. As one staff member noted, ***"patients become agitated here, making it difficult for us to support them."*** Another warned, ***"some patients are admitted medically fit, but they are still here weeks later, exposed to infection and further harm."***

These situations do not arise in isolation. They are the product of a fragmented system, where psychiatric bed shortages, delayed assessments, inadequate information-sharing, and disjointed community care pathways collide to leave vulnerable individuals in limbo. The emotional toll on hospital staff is considerable. Repeatedly, we heard of fear, trauma, burnout, and injury. ***"I have PTSD from working on Whitbread Ward,"*** one nurse reported, while another shared, ***"I felt scared at work — I didn't want to be left alone with certain patients."***

This issue is also having a ripple effect on other patients. Some have felt unsafe, distressed, or even physically harmed. Others have chosen to discharge themselves early, not because their care was complete, but because the environment became too hostile to bear.

Acute hospital wards were never designed to deliver long-term mental health care, and staff should not be left to manage extreme, complex needs without the training, support or infrastructure required. Yet what is now becoming common practice, sometimes for weeks or even months, is leaving patients and staff increasingly at risk, and is undermining the core function of both mental health and acute physical health services.

This report shines a light on a crisis that is under-recognised but growing in scale. It is not simply about capacity, it is about coordination, communication, workforce development and respect for the dignity and rights of people in mental health crisis. The stories shared here are not anomalies, they are systemic warning signals.

HWCB urges local system leaders across health, care, and community services to act decisively. This means investing in mental health capacity, improving information flow and discharge coordination, supporting frontline staff, and ensuring that no one in crisis is left stranded in a setting that cannot meet their needs. The system must now come together to turn these insights into impact, because the status quo is not just unsustainable; it is unsafe.

Recommendations

The findings of this review highlight an urgent need for coordinated system-wide action. The extended admission of mental health patients in acute hospital settings is not a symptom of isolated service failures, it is a systemic issue rooted in resource limitations, service fragmentation, and gaps in clinical and operational integration.

The recommendations below are grounded in the lived experiences of staff and patients and are designed to address the immediate and long-term challenges identified. They focus on ensuring timely access to specialist care, improving the safety and wellbeing of both patients and staff, and strengthening the pathways between acute, mental health, and community services. These are not just improvements, they are essential steps toward restoring dignity, safety, and effectiveness across the care system.

Improvement of Psychiatric Assessment and Bed Availability
Priority: High

Increase psychiatric bed capacity to reduce waiting times for patients in ED and wards, preventing extended stays in acute hospital environments.

Improve coordination between mental health and physical health services to streamline patient referrals and admissions, reducing delays in psychiatric care.

Enhance patient flow management by establishing clearer protocols for handling mental health patients, including prioritising timely psychiatric assessments and transfers to appropriate units.

Establish dedicated mental health beds in acute hospital settings for better management of patients in crisis, minimising the exposure of such patients to environments that exacerbate their conditions.

Safety and Support for Hospital Staff
Priority: High

Provide specialised training for hospital staff on how to handle mental health patients, including de-escalation techniques, restraint methods, and how to manage violent or aggressive behaviours safely.

Ensure proper support and supervision for staff, particularly in high-risk areas such as ED and psychiatric wards, to prevent burnout and trauma.

Introduce regular psychological support services for staff, including counselling or trauma-focused therapy, to address the emotional toll of caring for patients in crisis.

Create clearer protocols for managing aggressive patients, including securing resources like security staff and dedicated RMNs, ensuring the safety of staff and patients.

Integration of Mental Health and Physical Health Services
Priority: Medium

Develop better integration of mental health and physical health records so hospital staff can access comprehensive patient histories and triggers, enabling them to provide informed and tailored care.

Establish multidisciplinary teams that include both physical and mental health specialists, improving patient care and coordination across departments.

Addressing Social Factors and Delays in Discharge
Priority: Medium

Collaborate with social services to address homelessness, housing, and care packages, ensuring timely discharge and reducing delays caused by social factors.

Streamline the process for transferring patients to specialised mental health facilities and units that can address specific needs, such as eating disorder units, to avoid prolonged stays in acute care.care and coordination across departments.

Enhancing Patient Experience and Continuity of Care
Priority: High

Ensure continuity of care by assigning consistent staff (e.g., agency nurses) to mental health patients to build trust and reduce anxiety. Familiarity with a patient's history and behaviour can improve treatment outcomes.

Implement dedicated mental health care pathways that reduce the exposure of patients to the acute hospital environment, particularly for those without physical health issues.

Improving Communication and Information Sharing
Priority: High

Create systems for better communication between mental health professionals, hospital staff, and external agencies to ensure that all relevant patient information is available for clinical decision-making.

Develop robust handover procedures for staff, particularly in the transition of care for mental health patients, ensuring that the next caregiver is fully informed of the patient's needs and history.

Mitigating Impact on Other Patients
Priority: High

Implement strategies to reduce the negative impact on non-mental health patients, such as managing noise, ensuring mental health patients are separated where necessary, and improving staff ratios to ensure adequate care for all patients.

Offer alternative areas or wards for patients experiencing distress due to the presence of mental health patients, allowing them to feel safe and secure during their recovery.

Supporting Families of Mental Health Patients
Priority: High

Provide better support for the families of mental health patients, including clear communication, guidance on managing the emotional toll, and reducing the stigma associated with mental health care.

Introduce family counselling and support services to help family members cope with the challenges of having a loved one in crisis. departments.

Ensuring Appropriate Supervision and Staffing for Mental Health Patients in Acute Settings
Priority: High

Provide adequate specialist staffing when a mental health patient is transferred from a secure unit to a medical or surgical ward for physical health treatment, to support the patient safely during their stay.

Ensure patient receives appropriate supervision from a trained mental health nurse when presenting at the Emergency Department with mental health needs, to safeguard both the individual and the staff supporting them.

About Healthwatch Central Bedfordshire

Healthwatch Central Bedfordshire is the local consumer champion promoting choice and influencing the provision of high quality health, social care and wellbeing services for all across Central Bedfordshire.

Healthwatch Central Bedfordshire (HWCB) has significant statutory powers to ensure that the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services. HWCB engages and consults with all sections of the local population so that a wide cross-section of views are heard, understood and acted upon. Everything we say and do is informed by our connections to local people and our expertise is grounded in their experience.

Healthwatch Central Bedfordshire is one of three local Healthwatch in the County of Bedfordshire and belong to a network of local Healthwatch. Healthwatch England leads, supports and guides the Healthwatch network which is made up of the national body and local Healthwatch across each of the 152 local authority areas in England.

Healthwatch is the only body looking solely at people's experience across all health and social care. As a statutory watchdog our role is to ensure that local health and social care services, and the local decision-makers put the experiences of people at the heart of their care.

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