AGENDA ITEM No. 11

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

Meeting of East Renfrewshire Health and Social Care Partnership **Held on**	Performance and Audit Committee 25 June 2025
Agenda Item	11
Title	Specialist Learning Disability Inpatient Services Performance Report 2024/25

Summary

This paper provides the Performance and Audit Committee with data on the performance of Specialist Learning Disability Inpatient Services, with a particular focus on admission and discharge activity throughout 2024/25. The aim is to ensure visibility of the key issues for patients as well as highlighting areas for improvement.

Presented by	Tom Kelly, Head of Adult Services: Learning Disability and Recovery

Action Required

Performance and Audit Committee are asked to note and comment on the report.

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

PERFORMANCE AND AUDIT COMMITTEE

25 June 2025

Report by Chief Officer

SPECIALIST LEARNING DISABILITY IN PATIENT SERVICES PERFORMANCE REPORT 2024/25

PURPOSE OF REPORT

1. The purpose of this paper is to provide data on the performance of Specialist Learning Disability Inpatient Services with a particular focus on admission and discharge activity throughout 2024/25. The aim is to ensure visibility of the key issues for patients as well as highlighting areas for improvement

RECOMMENDATION

2. Performance and Audit Committee are asked to note and comment on the report.

BACKGROUND

3. This report focuses on activity relating to our assessment and treatment services (Blythswood House and Claythorn House) which have 27 beds across the two sites. The service is available to people with a learning disability residing in nine Health and Social Care Partnerships, six of which are within the NHS GGC boundary and three of which are provided via service level agreements in areas outwith NHS GGC.

4. The data in this report has been collected from our bed management system, EMIS and TrakCare. There are some limitations in the data provided due to the inclusion of patients admitted in the previous years but not yet discharged.

REPORT

Key Messages

5. The number of admissions increased by one in 2024/25, but overall figures remain just under 50% of the 2022/23 total. This trend is largely due to a significant drop in discharges from 15 in 2022/23 to just 7 in 2023/24.

6. Progress has been made in reducing delayed discharges this year with a total of 15 discharges. However, eight of the individuals discharged during 2024/25 had support packages dating back from previous years, four from 2022/23 and four from 2023/24 and. Only three individuals were able to return to homes they were admitted from. Despite the increased number of discharges in 2024/25, prolonged hospital stays due to delayed

discharge continue to impact a number of people and remain a key area for further improvement.

7. People are still more likely to be discharged within a reasonable timescale if their primary reason for admission is due to mental ill health and/or they have an established home to return to.

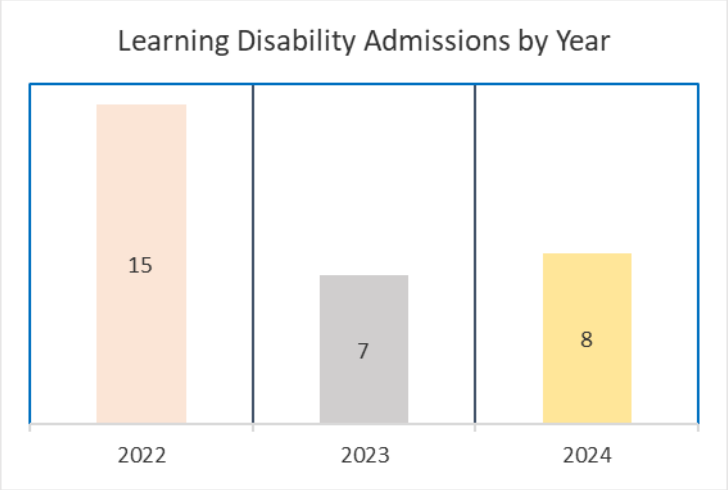
8. Establishing a new package of care and support is the primary reason for delays.

9. A high number of delayed discharges means we have a higher number of patients living together who do not want to be there/should not be sharing with others and as a result there is a high level of interpersonal risks that are difficult to manage.

10. When patients remain in hospital for extended periods and interpersonal risks escalate, this can complicate discharge planning as providers may become increasingly concerned about managing those risks in a community setting. We know with the right support, transitioning to the community based support remains a safe a positive step to improve a person's quality of life.

Overview of Activity in 2024/25

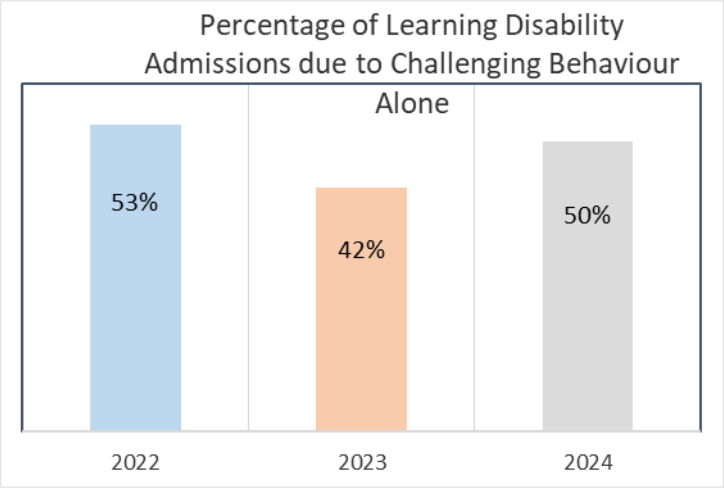
Admissions



11. The service received 21 referrals for admission to the LD inpatient service in 2024/25, but only a total of eight people were admitted. The data indicates a slight increase in referrals, suggesting a consistent demand for the service. However, the admissions trend from 23/24 remains, with the service experiencing low numbers of admissions as only one more person was admitted in 24/25. The service continues to face challenges related to discharges and length of stay, which impacts on the number of admissions. Of the eight admissions the age range was between 24 – 61 years.

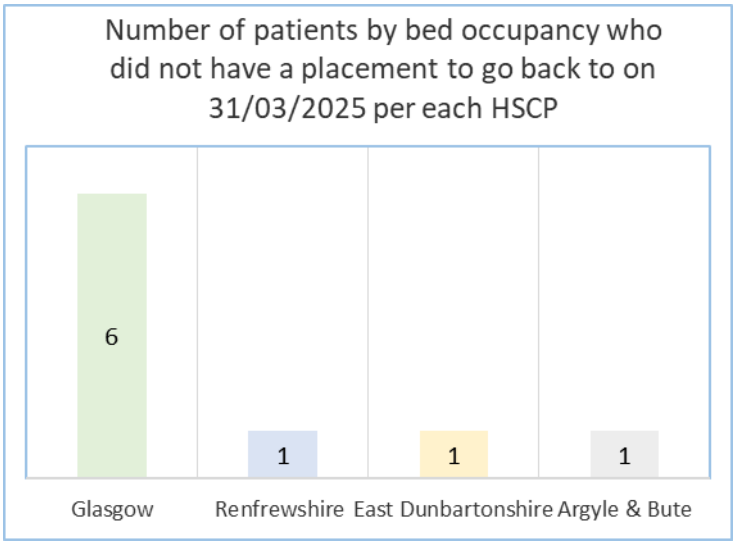
Reason for LD Admissions

12. In 2024/25, 50% of admissions were due to long-standing challenging behaviour (four out of eight), compared to 42% in 2023 and 53% in 2022. Most admissions for behaviours that challenge are linked to instability in community support, with staffing and recruitment issues in the Third Sector being a key factor

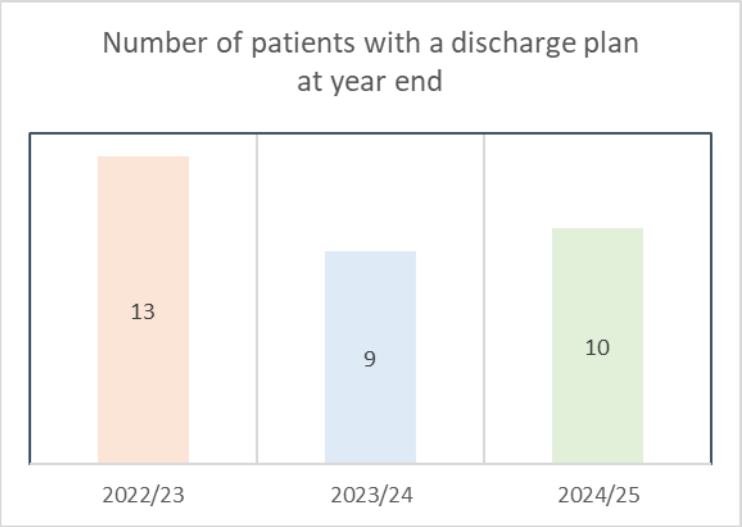


Number of patients without a discharge placement in LD Beds

13. On 31/03/2025 nine patients who were ready for discharge did not have a discharge plan / community placement.



Patients with a discharge plan in LD beds



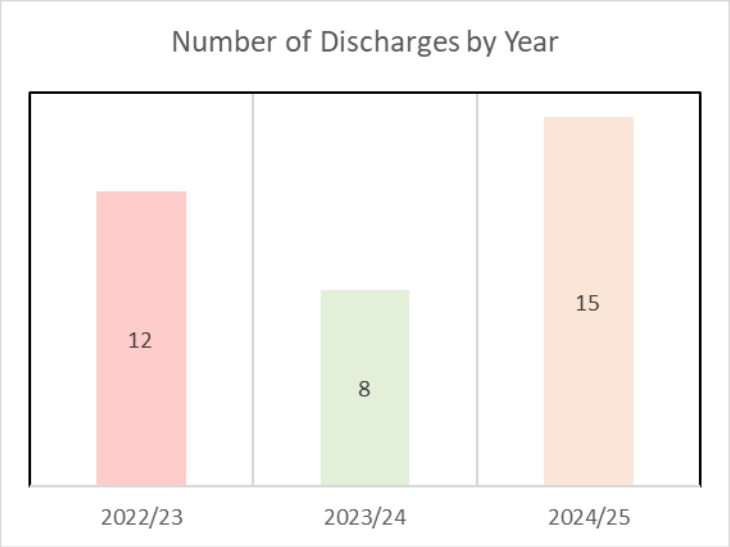
14. As of 31st March 2025, 10 out of 19 patients (53%) in LD inpatient services had an active discharge plan, showing slight improvement from 9 out of 26 (35%) in 2024. Despite this small progress, unacceptable delays in discharge remain a persistent issue, particularly for patients with longer hospital stays.

15. These delays are often due to complex needs and difficulty finding appropriate community placements. The prolonged delays in the ward contribute to increased interpersonal risks, including a rise of incidents in violence and aggression. These risks are managed through heightened levels of observation, placing additional strain on staff and resources.

16. The longer patients remain in hospital, the harder it becomes to identify suitable accommodation. This is partly due to a growing perception that their risks can only be managed in a hospital setting, which further complicates discharge planning and reinforces the cycle of delays.

Number of discharges & length of stay

17. In 2024/25, a total of 15 patients were discharged from the LD inpatient service, representing a significant increase compared to previous years with eight discharges in 2023/24 and 12 in 2022/23. This marks a 53% rise from the previous year and reflects notable progress. The improvement is largely attributed to some individuals having appropriate placements to return to, shorter hospital stays due to admissions focused on assessment and treatment rather than placement breakdown, and discharge planning had already begun for some people in 2022/23 and 2023/24. However, challenges remain, with several patients continuing to experience prolonged hospital stays due to the absence of clear discharge plans.

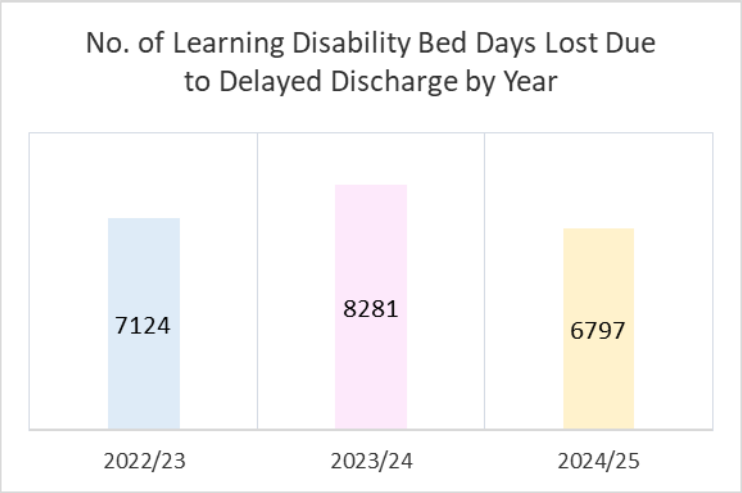


18. In addition to these, four long stay patients were discharged following the closure of the Netherton Unit in October 2024. All Netherton patients were temporarily transferred to Blythswood House due to delays with the completion of the new community placement. Three of the five transferred patients, and one long stay patient already accommodated in Blythswood House were discharged in December 2024 with four contingency beds being held for a period of three months. One patient remained in Blythswood due to legal complexities and the legal issues remained unresolved on the 31/03/25.

19. Overall the average length of stay counting all assessment & treatment LD patients discharged during 2024/25 was 145 days with a range between 0 – 358 days.

20. There is a correlation between the length of stay and accommodation status on admission. Of the fifteen discharges, three were returning to the home they were admitted from, with an average length of stay of 48 days. Eight had packages initiated in 2022/23 and 2023/24, three had new support packages identified in 2024/25 and one patient was transferred to IPCU. For these twelve patients during their admission the average length of stay was 567 days. This demonstrates patients that do not have appropriate accommodation and support packages experience prolonged hospital stays.

LD Bed days lost



21. Between 2023/24 and 2024/25, the number of bed days lost due to delayed discharges decreased by 20%, reversing the previous year's trend which saw a 14% increase from 2022/23 to 2023/24. When compared to 2022/23, the latest figures represent a 5% reduction in bed days lost indicating a positive trend.

HSCP Bed Activity in 2024/25

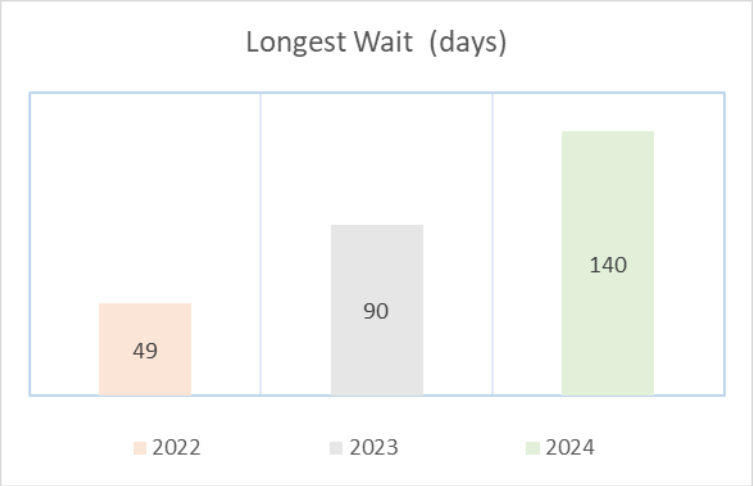
HSCP	Admissions to LD Beds	Discharges from LD Beds	Admissions to MH Beds	Discharges from MH Beds
East Dunbartonshire	3 (2 via MH bed)	0	1	2
East Renfrewshire	0	0	0	0
Glasgow	3 (2 via MH bed)	12	8	8
Inverclyde	1	0	1	2
Lanarkshire	1	0	0	0
Renfrewshire	0	3	0	0
West Dunbartonshire	0	0	3	3
Argyll & Bute	0	0	1	1
Total	**8**	**15**	**14**	**16**

LD Beds days lost by HSCP

HSCP	Bed days lost 22/23	Bed days lost 23/24	Bed days lost 24/25
East Dunbartonshire	0	1	181
East Renfrewshire	0	167	0
Glasgow	6293	5995	4579
Inverclyde	0	133	46
Lanarkshire	0	0	0
Renfrewshire	831	1465	1261
West Dunbartonshire	0	366	365
Argyll & Bute	0	143	365
TOTAL	**7124**	**8281**	**6797**

LD Waiting Times

22. The longest wait for admission to a learning disability inpatient bed was 140 days.



23. A group of people were removed from the waiting list as admission was no longer required or an alternative had been established before a bed became available for them.

Mental Health Adult Services Admissions (with no LD bed transfer)

24. The LD service is aware of 13 people open to community learning disability services who were admitted to a mental health bed during 2024/25 and were not subsequently transferred to an LD bed. One of these people had two admissions with the total number of mental health admissions not subsequently transferred to an LD bed at 14 for 2024/25.

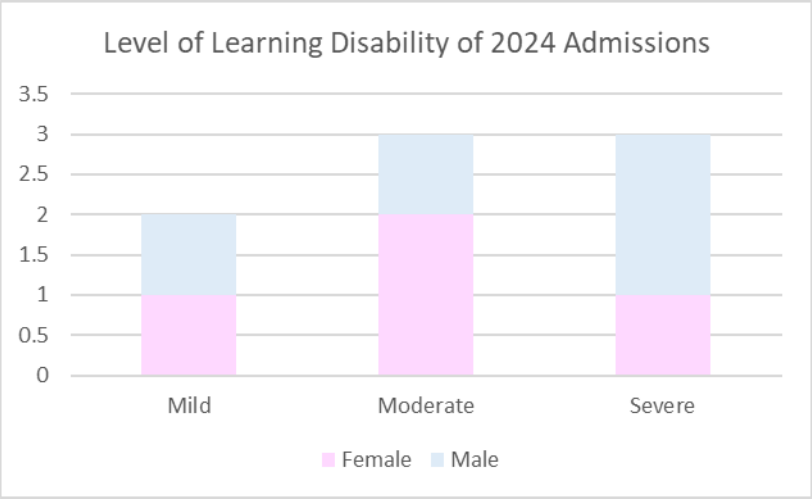
25. Six of these patients were referred to the LD inpatient service One patient remains in a mental health ward awaiting transfer to an LD bed and the other 5 were discharged directly from mental health. The remaining eight patients were assessed as having their mental health needs appropriately met within the mental health service and not in need of specialist LD inpatient care, and have since been discharged.

26. The average length of stay for LD patients discharged from a mental health bed during 2024/25 was 98 days with a range of 0 – 408 days.

Discharges 2024/25	**AVERAGE LENGTH OF STAY (days)**	**RANGE OF LENGTH OF STAY (days)**	**AVERAGE LENGTH OF STAY if returning home**	**AVERAGE LENGTH OF STAY if discharged to new placement**
LD patients in MH service	98	0 - 408	39	161
LD inpatients	145	0 - 358	48	567

5. Level of learning disability

27. Of the eight people admitted to LD inpatient services the level of learning disability was predominantly moderate and severe / profound learning disability, this is consistent with the pattern of admissions since 2023.



CONCLUSIONS

28. The Community Living Change Fund which was allocated for use over a three year period (2021 – 2024), has now concluded. The fund supported the redesign of services for people with complex needs including learning disabilities and autism, and for people who have enduring mental health problems. The achievements of the fund laid important groundwork for continued improvements; the admission and discharge data indicates that whilst some improvement has already been achieved, further work is needed to reduce prolonged delays in hospital for those in need of a new community placement.

29. In 2024/25, two HSCPs demonstrated a shift in admissions to the SLDS inpatient service. Renfrewshire HSCP recorded no admissions to the service, the first this has occurred since 2019. Historically the service has seen an average of approximately three admissions per year. In contrast, East Dunbartonshire HSCP recorded three admissions to the SLDS inpatient service in 2024/25, the highest number since 2019. Admissions have gradually increased over the period, rising from zero between 2019 and 2021, to one admission per year in 2022 and 2023.

30. NHS GGC has successfully closed its final remaining long stay unit, with all remaining patients now discharged. This marks a significant milestone in the SLDS Inpatient redesign and was a key objective of the Community Living Change Fund.

31. A collaborative approach across HSCPs in order to ensure local objectives align and shape the future design of both community and inpatient services is in place.

32. Our LD Programme Board and both the Multi-Agency Collaborative Commissioning Group will continue to lead the development of responsive community based support, with the aim of reducing inappropriate hospital admissions and delayed discharges. Commissioners from each HSCP are actively working to identify opportunities for joint working across NHS GGC.

33. Performance across 2024/25 has demonstrated measurable improvement, with an increase in discharges from the LD inpatient service. However, persistent delays remain a significant operational challenge, limiting our ability to admit directly when there is a need for assessment and treatment. Notably, admissions increased slightly this year, with one additional patient compared to 2023/24. A waiting list is currently in place and all new admissions are dependent on timely discharges.

34. Lack of suitable accommodation and tailored support packages continue to be a key factor contributing to prolonged delays in hospital. The data has again shown that patients admitted to a mental health ward are discharged to a new placement significantly sooner than those admitted to the LD inpatient service.

35. Some provider organisations have reported improvements in recruitment, however instability within community supports services remain a concern, particularly for young adults with learning disability and autism. High staff turnover has a negative impact, as consistency of care and support is essential.

36. The Dynamic Support Register is a key component of the Coming Home Implementation Report. This allows HSCPs to identify and monitor people with learning disabilities who are at risk of hospital admission, placement breakdown and inappropriate out of area placements. The register allows HSCPs to improve their ability to plan proactively, coordinate support more effectively and intervene to prevent crisis.

37. As part of the ongoing inpatient service redesign, we continue to prioritise the development of effective alternatives to hospital admission. In 2024/25, the service successfully piloted an outreach model, delivering targeted community based support that resulted in positive patient outcome and avoided the need for hospital admission. Building on this success, an operational policy has been developed to formalise the outreach approach, including partial admissions and intensive discharge support.

38. The vision for learning disability inpatient services:

'We believe that people with learning disabilities should be given the right support so that they can live fulfilling lives in the community. This support should always be person centred, preventative, flexible and responsive. People should only be admitted to inpatient assessment and treatment services when there is a clear clinical need which will benefit from hospital based therapeutic intervention. Challenging behaviour, with no identified clinical need, is not an appropriate reason to admit people to inpatient assessment and treatment services.'

RECOMMENDATIONS

39. Performance and Audit Committee are asked to note and comment on the report.

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May 2025

Chief Officer, IJB: Alexis Chappell

BACKGROUND PAPERS

PAC Paper – 26 June 2024
https://www.eastrenfrewshire.gov.uk/media/10456/PAC-Item-10-26-June-2024/pdf/PAC_Item_10_-_26_June_2024.pdf?m=1718729971563