**AGENDA ITEM No.12**

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

| | |
|---|---|
| **Meeting of East Renfrewshire Health and Social Care Partnership**<br><br>**Held on** | Integration Joint Board<br><br>21 September 2022 |
| **Agenda Item** | 12 |
| **Title** | Specialist Learning Disability In Patients Performance Report |


**Summary**

This paper outlines the annual performance of the specialist learning disability in patient service for the calendar year 2021 in addition year to date performance information for 2022 is provided.


| | |
|---|---|
| **Presented by** | Tom Kelly |

**Action Required**

The Integration Joint Board are asked to:-

- Note the Performance and Audit Committee recommendation to share the performance report for this service for the calendar year 2021 along with year to date data for 2022.
- Agree that this information is shared with the partner HSCPs within NHSGGC.

| **Directions** | **Implications** | |
|---|---|---|
| ☒ No Directions Required | ☐ Finance | ☐ Risk |
| ☐ Directions to East Renfrewshire Council (ERC) | ☐ Policy | ☐ Legal |
| ☐ Directions to NHS Greater Glasgow and Clyde (NHSGGC) | ☐ Workforce | ☐ Infrastructure |
| ☐ Directions to both ERC and NHSGGC | ☐ Equalities | ☐ Fairer Scotland Duty |

**EAST RENFREWSHIRE INTEGRATION JOINT BOARD**

**21 September 2022**

**Report by Chief Officer**

**Specialist Learning Disability In Patients Performance Report**

## PURPOSE OF REPORT

1. The purpose of this report is to provide the IJB with the performance report for this Specialist Learning Disability In Patients service for the calendar year 2021 along with year to date data for 2022. Following discussion at the June Performance and Audit Committee it was agreed that this information would be of interest to the IJB and the committee suggested the report should also be shared with partner HSCPs within NHSGGC.

## RECOMMENDATION

2. The Integration Joint Board is asked to:-

   - Note the Performance and Audit Committee recommendation to share the performance report for this service for the calendar year 2021 along with year to date data for 2022.
     .

   - Agree that this information is shared with the partner HSCPs within NHSGGC.

## BACKGROUND

**3.** The report included at appendix 1 was presented to the June Performance and Audit Committee. Following discussion it was recommended that the report covering the calendar year 2021 along with year to date information to June 2022 be shared with the Integration Joint Board. Members of that committee also considered the information would be useful to support governance and decision making across our partner HSCPs.

## REPORT

4. As has been the case annually since East Renfrewshire began hosting the service an annual performance report has been produced and presented to the Performance and Audit Committee

**5.** The performance report for calendar year 2021 was discussed at the June Performance and Audit Committee. The committee noted the main points of the report and asked that further data be included to outline the position to this point in 2022. The report has been updated with 2022 data to June, this is featured in section 7 of the appended report.

## CONSULTATION AND PARTNERSHIP WORKING

6. East Renfrewshire hosts the in patient service on behalf of NHSGGC therefore the performance relating to admission and discharge is determined by activity across all HSCPs.

## IMPLICATIONS OF THE PROPOSALS

7. There are no implications arising as a result of this report.

## DIRECTIONS

8. There are no directions arising as result of this report.

## CONCLUSIONS

9. This paper outlines the annual performance of the specialist learning disability in patient service for the calendar 2021 in addition year to date performance information is provided.

## RECOMMENDATIONS

10. The Integration Joint Board is asked to:-

- Note the Performance and Audit Committee recommendation to share the performance report for this service for the calendar year 2021 along with year to date data for 2022.
- Agree that this information is shared with the partner HSCPs within NHSGGC.

## REPORT AUTHOR AND PERSON TO CONTACT

Tom Kelly
Tom.kelly@ggc.scot.nhs.uk

Chief Officer, IJB: Julie Murray

# PERFORMANCE REPORT
# SPECIALIST LEARNING DISABILITY IN PATIENT SERVICES

**April 2022**

**Julie Fitzpatrick, Service Manager Specialist Learning Disability Services**
**Margaret Mason, Challenging Behaviour Network Manager**

## 1. PURPOSE

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 **2021**. We have also included data in section 7 of the report which covers the first half of 2022 and summarises recent activity. The aim is to ensure visibility of the key issues for patients as well as highlighting areas for improvement.

## 2. BACKGROUND

This report focuses on activity relating to our Assessment and Treatment Services (Blythswood House and Claythorn House) which has 27 beds across the two sites. The service is available to people with a learning disability residing in 9 Health and Social care Partnerships, 6 of which are within the NHS GGC boundary and 3 of which are provided via service level agreements in areas outwith NHS GGC.

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 patients admitted in the previous years but not yet discharged being included in this report. There was also missing data for the number of individuals appropriately admitted to mental health care, and had not needed specialist learning disability inpatient care.

## 3. KEY MESSAGES

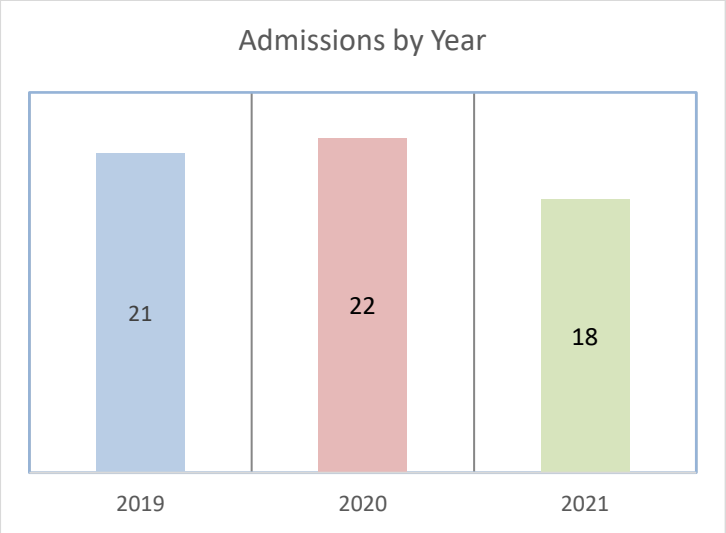
- The service continued to operate fully throughout the pandemic despite many COVID challenges. Blythswood had to close to admissions when in outbreak status – which happened on only one occasion. Claythorn has never had a COVID outbreak.
- Beds were mainly occupied by people who were admitted due to mental illness (58%). However, there was an increase in admissions due to challenging behaviour alone from previous years (42% compared to 32% in 2020). There has also been an increased profile of patients with complex needs.
- Delayed discharge caused significant issues, with a number of patients having no discharge plan for a significant period of time nor a home to return to. The reasons for delay were due to no suitable accommodation and/or no providers in place and/or providers in place having real difficulty with recruitment.
- People are still more likely to be discharged within a reasonable timescale if their primary reason for admission is due to mental ill health.

## 4. REPORT

**Overview of Activity in 2021**

4.1 Admissions

Chart 1

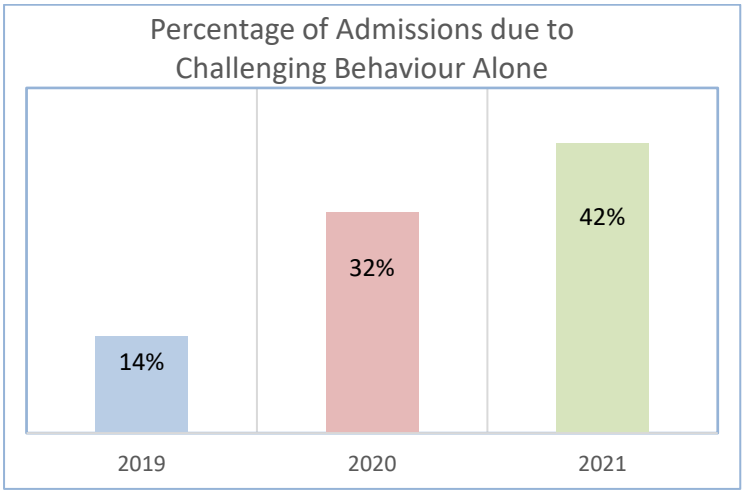



In total 18 people were admitted in 2021. This is a reduction of 4 from the previous year and relates directly to a smaller number of discharges during 2021. However, more people were admitted than discharged due to the use of a contingency bed in Claythorn.

Of the total numbers of referrals received 9 of the patients were admitted directly to the service (50%), the remainder through general adult mental health services first.

4.2 Reason for Admissions

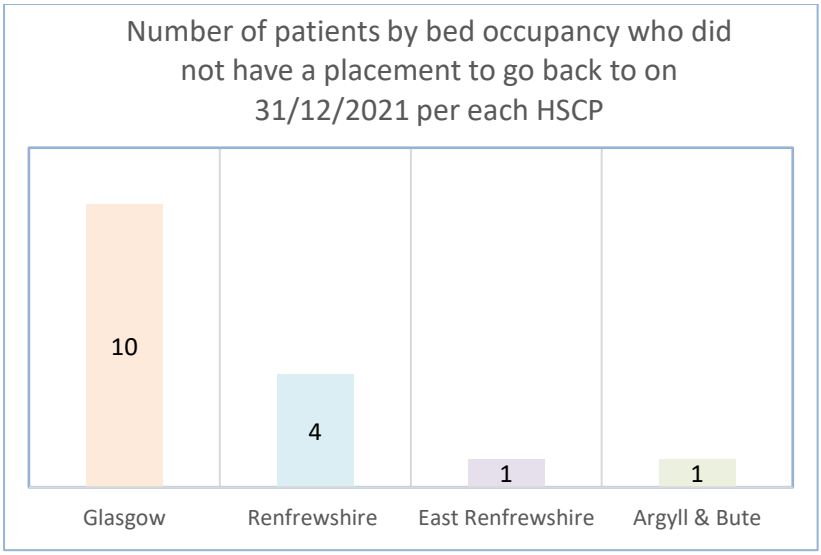
Chart 2




There was an increase in admissions due to challenging behaviour alone from previous years (42% compared to 32% in 2020). This may be have been due to the Covid pandemic related reduction in some community supports and provider staffing issues resulting in community services being overall less able to support those with the most challenging behaviour.

4.3 Number of patients without a placement

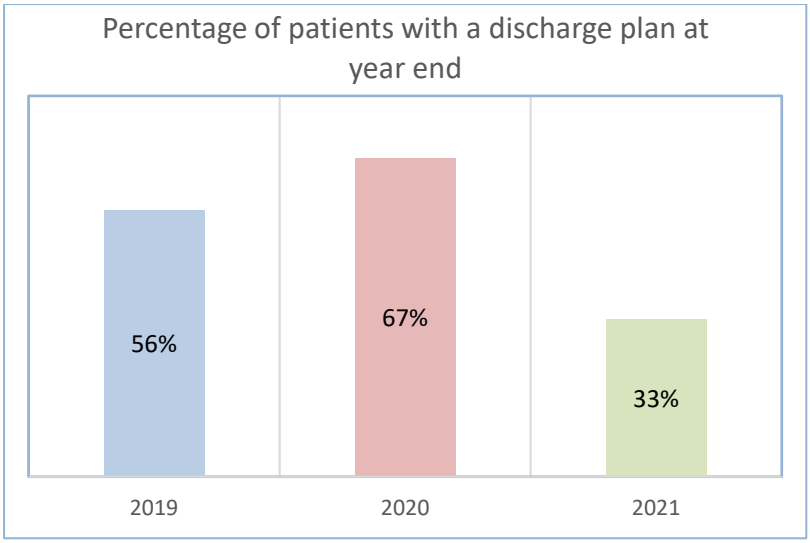
Chart 3




16 inpatients on the 31/12/21 were noted to not have a home to return– they had no community placement. This is over half the patient group and reduces the ability of the service to successfully manage patient flow.

4.4 Patients with a discharge plan

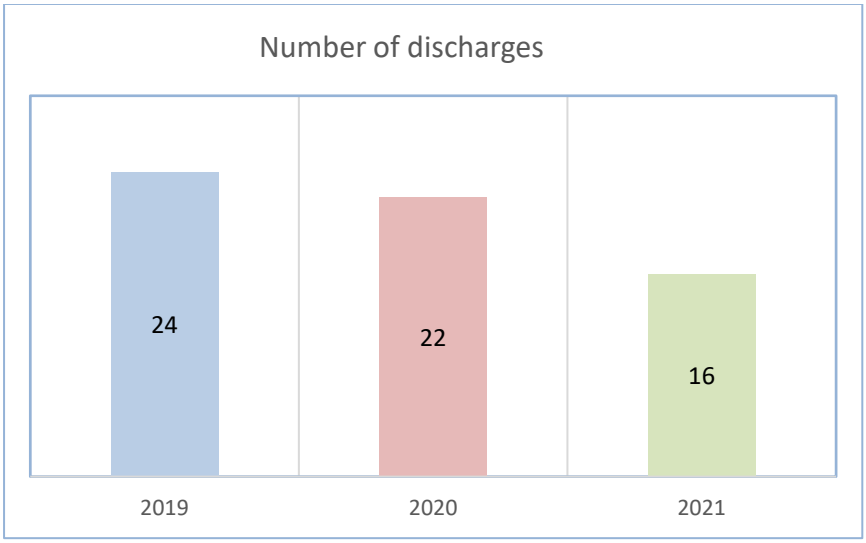
Chart 4




Only 33% of inpatients had a discharge plan on the 31/12/21.This was a significant reduction in the number from the previous year of 67%. Some patients have been waiting a long and unacceptable time for discharge. One patient has been waiting to move out of learning disability hospital provision since **2016**.

4.5 Number of discharges

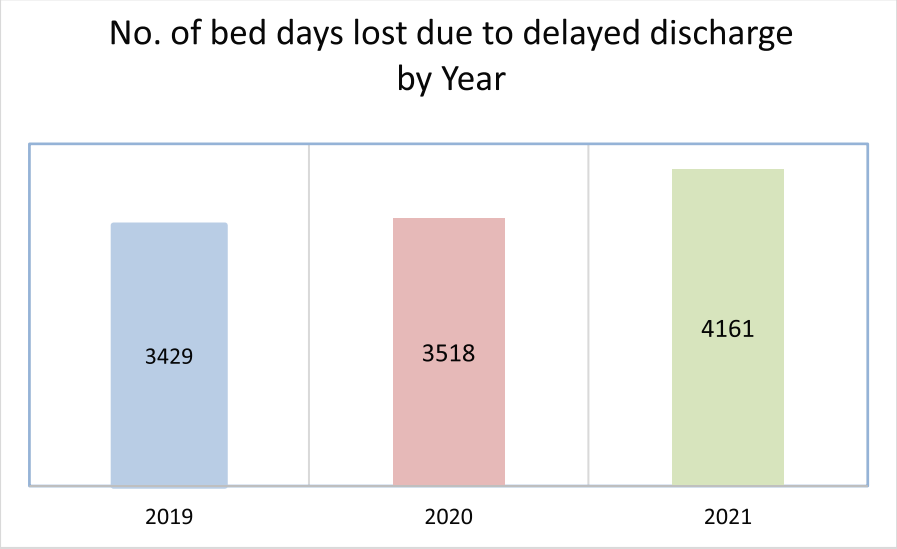
Chart 5




16 patients were discharged in 2021 compared with 22 discharges in 2020. One person discharged was re-admitted in the same year (2021) as a result of placement breakdown. The average length of stay for those patients discharged in 2021 was **294** days with a range of 12-694 days. For patients able to be discharged back home during 2021 the average length of stay was 106 days (range 12-211 days) and for patients requiring a new placement to be discharged to during 2021 the average length of stay was 407 days (range 190-694 days).

4.6 Bed days lost

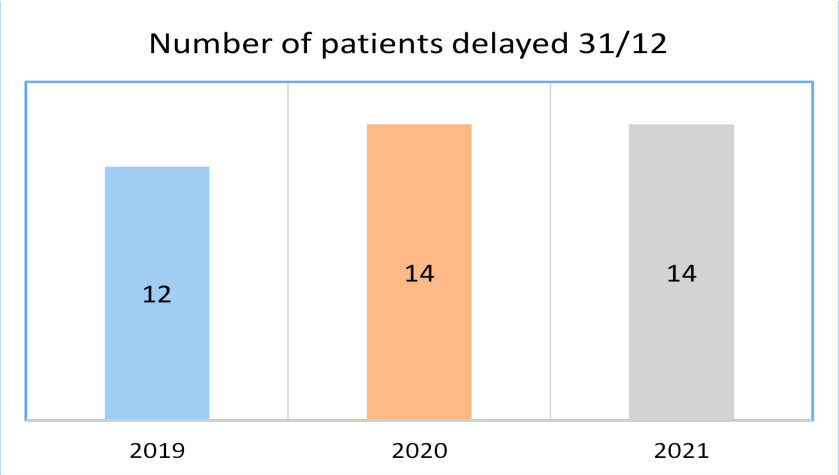
Chart 6




There was a 15% increase in beds days lost due to delayed discharge from 2020 to 2021.

4.7 Number of patients delayed at the end of each year

Chart 7




The number of patients delayed on 31/12/21 did not improve from 31/12/20. Over half the patient group (53%) were delayed.

4.8 HSCP Activity in 2021

Table1

| | | 2021 | |
|---|---|---|---|
| **HSCP** | **Total Referrals** | **Admissions** | **Discharges** |
| Argyll & Bute | 1 | 1 | 0 |
| East Dunbartonshire | 0 | 0 | 0 |
| East Renfrewshire | 2 | 2 | 1 |
| Glasgow | 12 | 9 | 6 |
| Inverclyde | 3 | 1 | 3 |
| Lanarkshire | 0 | 0 | 0 |
| Renfrewshire | 5 | 5 | 4 |
| West Dunbartonshire | 0 | 0 | 2 |
| Total | 21 | 18 | 16 |

4.9 Beds days lost by HSCP

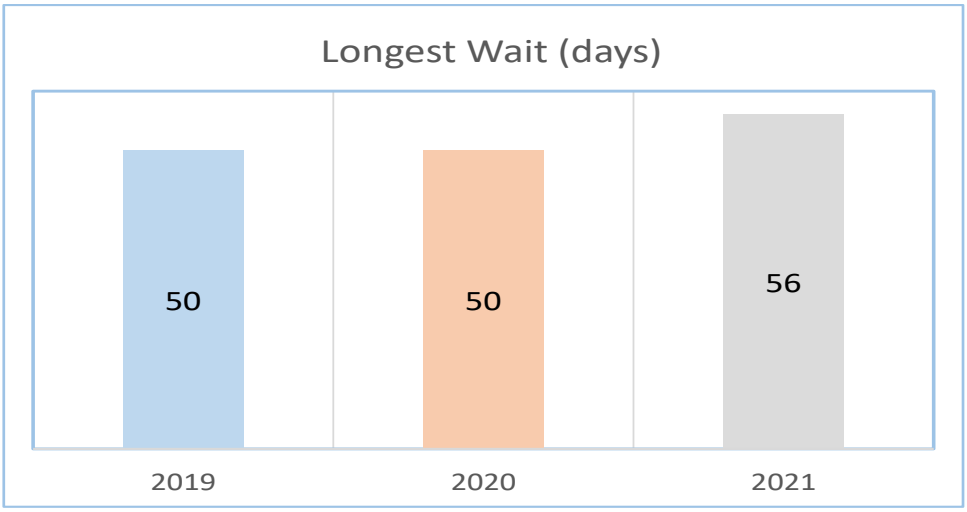
Table 2

| **HSCP** | **2019** | **2020** | **2021** |
|---|---|---|---|
| Argyll & Bute | | | 0 |
| East Dunbartonshire | | | 0 |
| East Renfrewshire | | | 28 |
| Glasgow | | | 2100 |
| Inverclyde | | | 362 |
| Lanarkshire | | | 0 |
| Renfrewshire | | | 1091 |
| West Dunbartonshire | | | 580 |
| Total Days | 3429 | 3518 | 4161 |

Chart 7


4.10 Waiting Times

Chart 8




The longest wait for a bed was **56** days and this patient went first into a mental health bed before being transferred to a Learning Disability bed.

As a result of continuous occupancy, the service is often unable to directly admit several people requiring specialist learning disability assessment & treatment.

A group of people were removed from the waiting list as admission was no longer required or an alternative had been established.

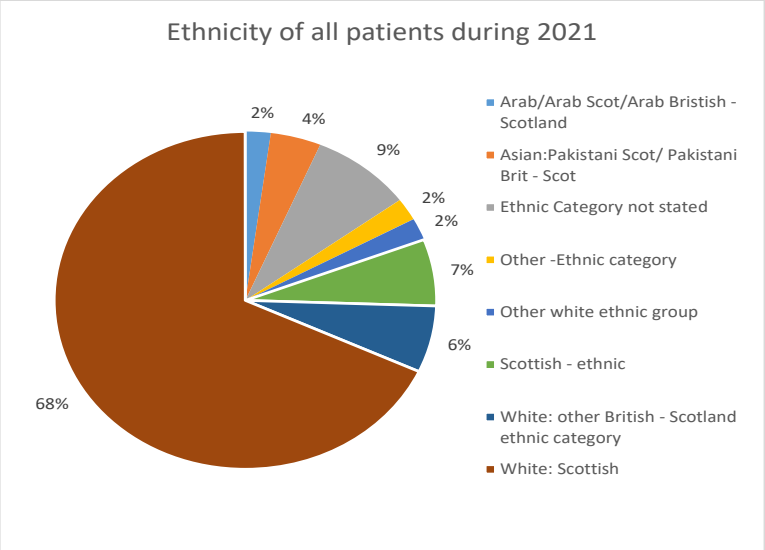
4.11 Mental Health Adult Services Admissions (with no LD bed transfer)

The LD service is aware of at least 9 patients with LD that were admitted to a mental health bed during 2021 that were then not transferred to a learning disability bed, and remained in a MH bed throughout their inpatient stay.

## 5. Patient Characteristics Data

5.1 Ethnicity

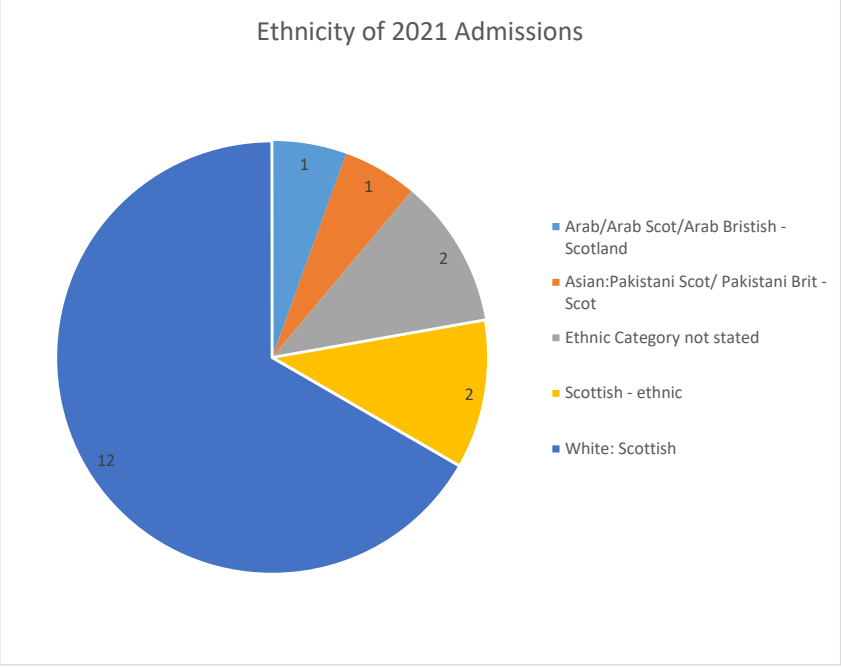
Chart 10




The largest ethnic group of patients described in patient records in 2021 is 'white Scottish'. The categories overlap somewhat and require a clearer delineation going forward.

The largest ethnic group by admission in 2021 is 'Scottish'.

Chart 10



5.2 Gender

There were slightly more female admissions in 2021 compared to males. This is unusual as in other years there were typically more males admitted.

Chart 11

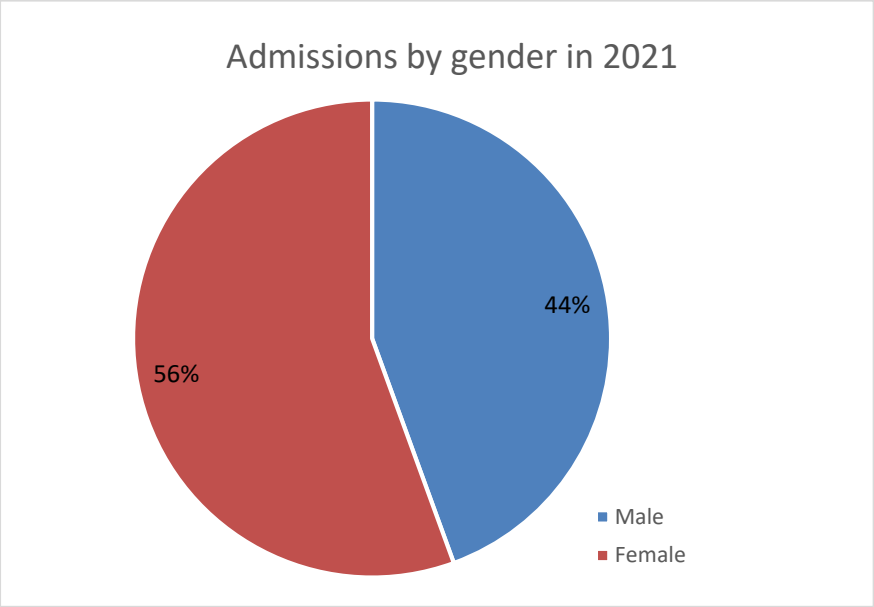
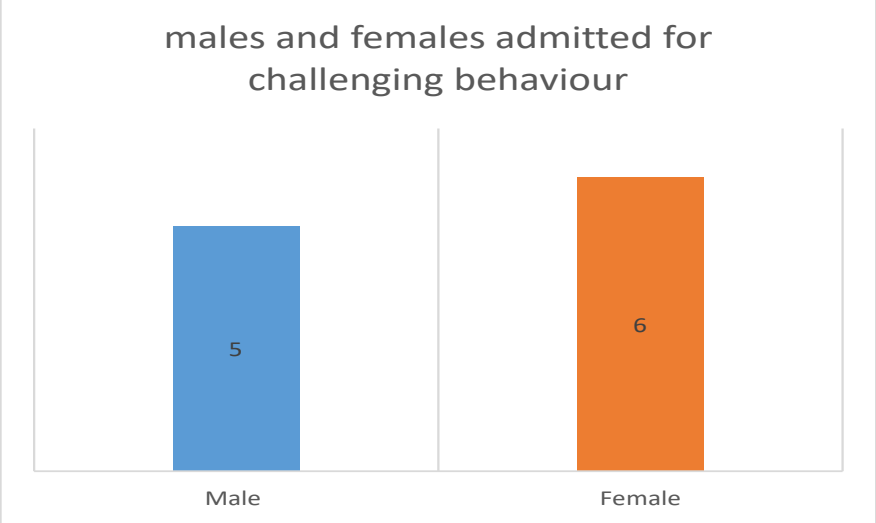


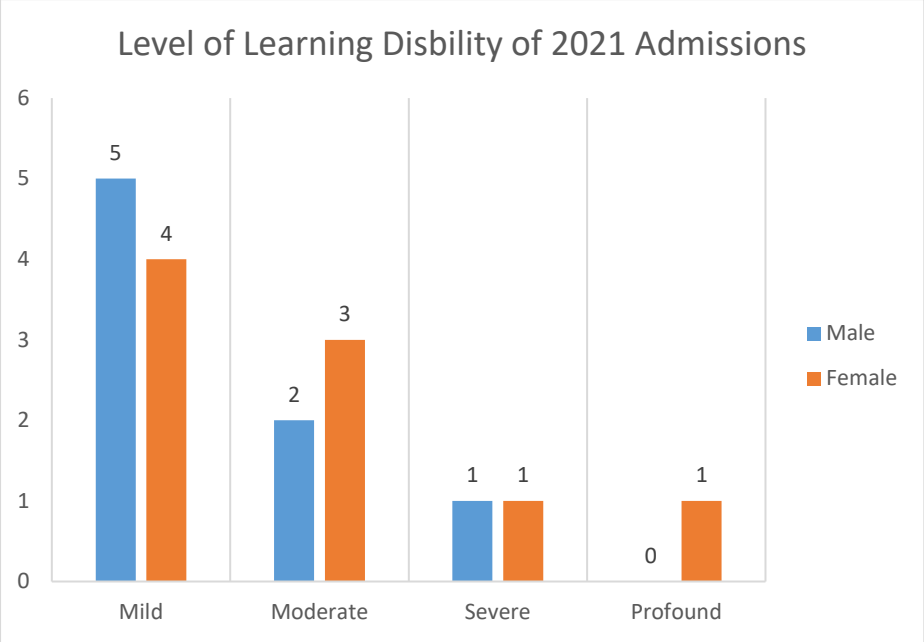

Chart 12




There was slightly more females admitted (6) for challenging behaviour compared to males (5) in 2021.

5.3 Level of learning disability

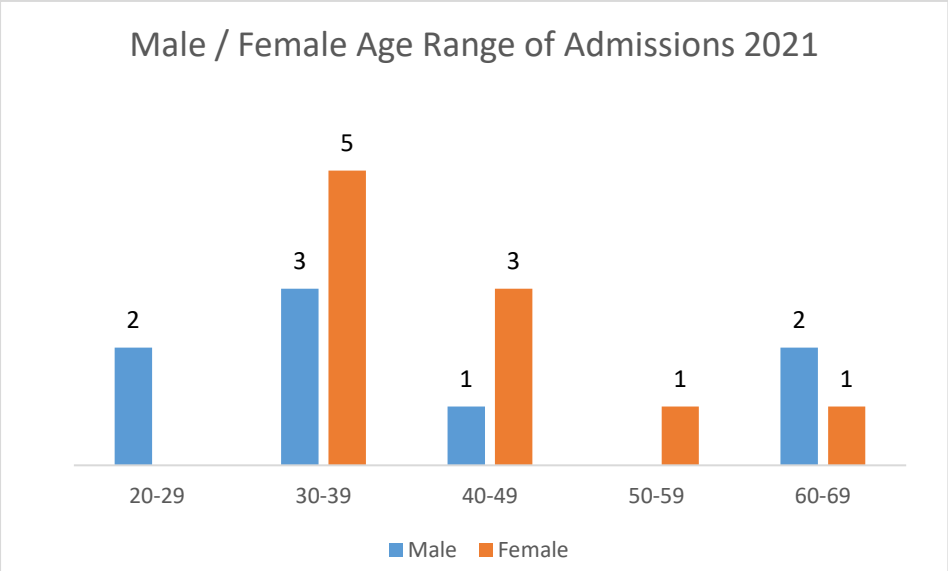
Chart 13




The level of learning disability was predominantly a mild learning disability followed by moderate for those people admitted in 2021. Only three people had a severe learning disability and one person a profound learning disability. People with a mild learning disability are therefore over represented and people with a profound learning disability underrepresented in comparison to general learning disability population figures.

5.4 Age range of patients admitted in 2021

Chart 14




Most patients admitted were in the age range between 30-39 with an average age of 41yrs but the service also admitted young men and older people up to the age of 69.

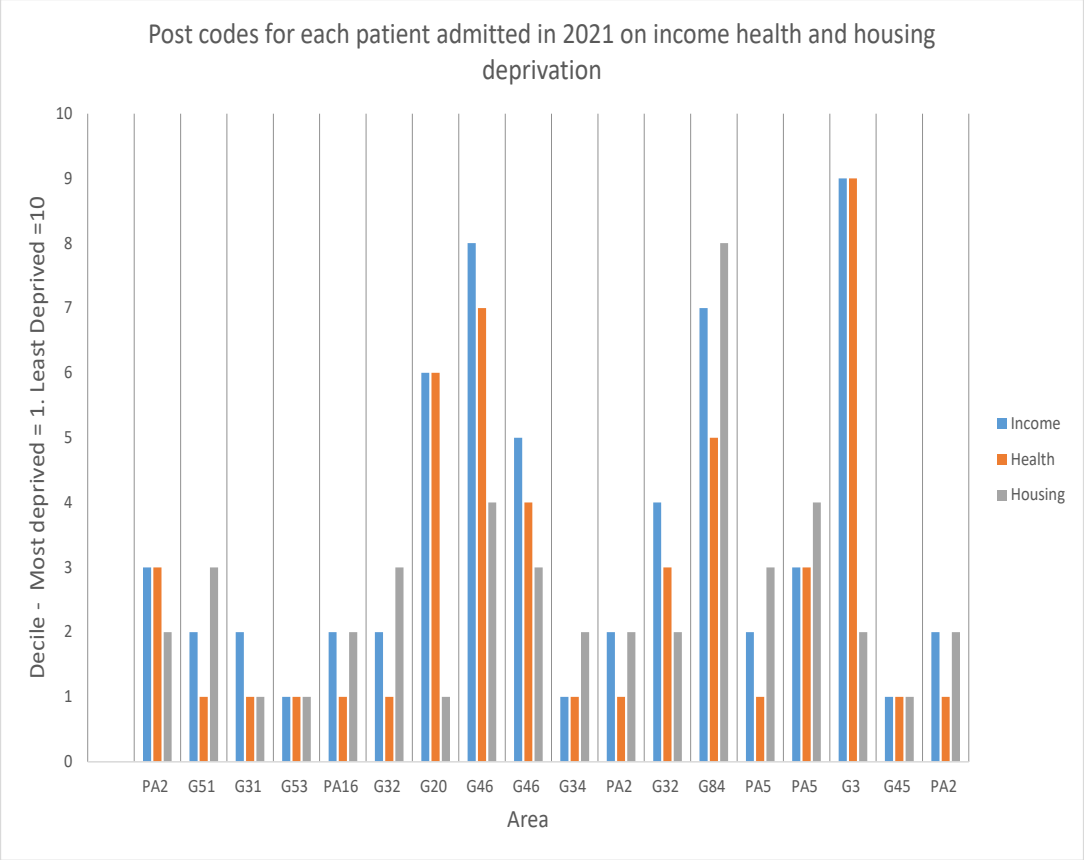
5.5 Levels of deprivation

Levels of deprivation are usually measured across several types domains including employment, health, education, and crime, access to housing and services and living environment. The ranking system goes from the lowest 1 being most deprived to the highest 10 least deprived.

11 patients admitted to learning disability services came from areas that did not surpass a ranking of 3 on the deprivation scale for their postcode area which means 11 patients came back from deprived areas.

Chart 15 shows the deprivation levels for every patient admitted in 2021 in 3 of the main domain types for income, health, and housing.

Chart 15




## 6. HoNOS – Learning Disability (Health of the Nation Outcome scales) data

6.1 Overview

Inpatient Learning Disability services have been using the outcome measure HoNOS-LD since 2015. All patients admitted to a Specialist Learning Disability Service have a HoNOS-LD completed by the Multi-Disciplinary Team on admission, at discharge and on a regular basis during admission (3 or 6 monthly as per protocol). The results across all inpatient units are collected and analysed centrally.

6.2 Full results

A total of 252 HoNOS-LD were completed over the 3 year period 2018-2021, with 77 completed over 2021. This represented a total of 82 patients over all three inpatient units.
Results were available from each of the units as follows:
Claythorn = 142 results from 66 patients
Blythswood House = 77 results from 38 patients
Netherton = 33 results from 10 patients

6.3 Active treatment

There were a total of 171 HoNOS-LD completed for 62 episodes of care including 6 readmissions during 2018-2021. The first and last HoNOS-LD recorded during active treatment were compared to look for a change in score. The results were as follows:
Subjective ratings:
First score mean = 2.5, median = 3, range = 0 - 4
Last score mean = 1.4, median = 1, range = 0 - 4
Total scores:
First score mean = 23.8, median = 26.5, range = 1 - 48
Last score mean = 11.4, median = 11, range = 1 - 42

This shows an improvement in both subjective and total scores, although note that some patients were still significantly unwell at the point of the second scores (which is explained by the fact that they were not necessarily ready for discharge by this point). These numbers are very similar to the previous year's analysis. Overall, it shows that patients get better and improve following learning disability inpatient care.

## 7. January to July 2022 Inpatient Data Update

See table 3 for an overview of current inpatient activity across HSCPs for the first half of this year.

In the first half of 2022 there were 7 people admitted. 5 were from Glasgow, 1 Inverclyde and 1 Renfrewshire. 5 of the admissions were for challenging behaviour reasons and 2 for mental illness. The service also provided outreach support to 1 person in Inverclyde and an admission was avoided. 3 out of these 7 patients admitted have no home to go back to due to family breakdown and 1 person's circumstances remains unclear. 2 have been discharged back to their family home. There were a total of 5 discharges in this same period.

See table 4 for overview of delays in January – July. At the end of July there were 17 patients who were delayed. Whilst 9 of those individuals had some level of plan for discharge 6 of those were stalled due to a combination of issues but mainly provider recruitment challenges. This has a detrimental impact on patients who are fit for discharge, cannot leave hospital in a timely manner, and can become more unwell or experience emotional distress as result of the delay. Effectively out of 17 patients who were delayed at the end of July only 3 had a definite plan with a discharge date or who could be considered as working towards a confirmed discharge date. It also prevents the service being able to admit.

There were an additional 3 individuals from Glasgow who were admitted to general adult MH services who did not require specialist learning disability services.

Table 3

| | | Jan to 31st July 22 | | |
|---|---|---|---|---|
| **HSCP** | **Referrals** | **Admissions** | **Discharges** | **Delays** |
| | | | | |
| East Dunbartonshire | 0 | 0 | 0 | 0 |
| East Renfrewshire | 0 | 0 | 1 | 0 |
| Glasgow | 6 | 5 | 2 | 10 |
| Inverclyde | 2 | 1 | 0 | 1 |
| Renfrewshire | 2 | 1 | 2 | 5 |
| West Dunbartonshire | 0 | 0 | 0 | 1 |
| | | | | |
| Total | 10 | 7 | 5 | 17 |

Table 4

*Plan, describes definite plan with expected discharge date.

| **HSCP** | **Delays** | **Plan** |
|---|---|---|
| Glasgow | 10 | 1 |
| Renfrewshire | 5 | 1 |
| West Dunbartonshire | 1 | 0 |
| Inverclyde | 1 | 1 |
| | | |
| Total | 17 | 3 |

8. Case Example of Successful Discharge

Despite the challenges of delayed discharge, below provides a case example that highlights how collaborative working can lead to a timely successful discharge in order to support someone to live a good life.

Zain (pseudonym) lived with family and was admitted to hospital due to distress and challenging behaviour. Despite the best efforts of all concerned his distress was such that the hospital admission was unavoidable and from there it was apparent to all concerned that he could not return to his previous living circumstances. The community team led a collaborative effort to ensure Zain would be able to move on from hospital as soon as he was ready to do so.

Leading up to the admission community and inpatient staff supported Zain and his family through the process, developing social stories to communicate to him he was going to spend some time in hospital. Zain was drove in his own car to hospital as this was least distressing for him and his parents. The community team at the same time identified a vacant housing association property and put an application in on behalf of Zain. This was viewed by the family and OT as being suitable with some adaptations.

During hospital admission community staff worked closely with the inpatient team

attending weekly multi-disciplinary meetings to share information and knowledge. Within the community the discharge planning started within the first week of Zain's admission. This involved care plan meetings with the family and ward to identify what model of care would suit Zain's needs when he was ready for discharge.

Prior to discharge the community team met with the ward, the provider and family in order to review support strategies, complete risk assessments and protocols. The 3 week transition period from hospital to community took robust planning with everyone involved to ensure Zain had the best opportunity to settle into his new home.

Zain remains on the dynamic support register and the community learning disability team remain regularly involved. Weekly meetings continue to monitor and review support strategies and risk assessments and look at future planning to ensure Zain continues to have a good quality of life in the community.

## 7. Summary and Actions

- NHS GGC HSCPs had committed to working together in 2019 to take forward a programme of redesign of inpatient services, the emphasis being on improving our responses in the community to reduce the use of inpatient beds when not clinically required. We had highlighted a need to review and improve performance in delayed discharge and have worked positively with Scottish Government to shape the original 'Coming Home' report in 2018 – this led to the publication of the recent 'Coming Home Implementation' 2022 report.

- Alongside this, the allocation of the Community Change Fund aligns to NHS GGC ambitions to redesign services for people with complex needs including learning disabilities and autism, and for people who have enduring mental health problems. NHS GGC have now developed a programme board which will provide strategic leadership and governance and direct the work of the community and inpatient redesign going forward. Avoiding admission and preventing placement breakdown is a key priority to addressing delayed discharges.

- Each HSCP has committed to develop a register of people with complex needs to ensure greater visibility of these individuals at risk of hospital admission and/or placement breakdown and the Challenging Behaviour Network Manager has been developing good practice standards and pathways to support this.

- Our in-patient services had embarked on a series of tests of change led by the Clinical Director, looking at a variety of approaches to reduce unnecessary admissions and support people at home. Future redesign of the service is dependent on excessive delays being addressed in order to effectively implement change in patient bed requirements.

- Many people are still delayed in hospital and do not have a clear and tangible plan about their future care arrangements. This has been more present in the past two years since the onset of the pandemic.

- There is a fundamental human rights issue for the people who find themselves living in hospital settings for prolonged periods often with no plan for discharge which must be addressed. There are further negative implications for families and carers.

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.'***