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Agenda Item: 6

Integration Joint Board

Date of Meeting: 2 July 2025.

Subject: Delayed Transfers of Care – System Pressures.

1. Purpose

1.1. To provide Members with information on delayed transfers of care.

2. Recommendations

It is recommended:

2.1. That a Short Life Working Group, the membership of which will include appropriate Heads of Service, Service Managers and other key stakeholders, be established to review discharge processes, delayed transfers of care and options for working differently/creating system capacity.

2.2. That the Short Life Working Group should report back to the Board on the outcome of its deliberations no later than December 2025.

3. Background

3.1. The First Minister and Cabinet Secretary set out the mission to reduce delayed transfers of care in July 2024. The Collaborative Response and Assurance Group (CRAG), Scottish Government, COSLA and local system leaders agreed a joint approach to significantly reduce the level of delayed transfers of care to pre-pandemic levels and address the observed variability across the country in achieving this. Although this is clearly not the only pressure across the health and care system, there is an urgent need to reduce delayed discharges to prevent avoidable harm.

3.2. A delayed transfer of care occurs when a patient who is medically ready for discharge from a hospital, or other care setting, remains in that setting due to non-clinical reasons. This means a patient is ready to move to a different care setting (like home, sheltered housing or supported accommodation, care home or community hospital) but is unable to do so, often due to a lack of available social care, funding issues, or other logistical hurdles.

3.3. These delays can have negative impacts on patients, including increased mortality, infection, and reduced mobility. Evidence shows that lengthy periods of unnecessary bed rest can lead to severe muscle wastage, pressure sores, loss of independence and confidence, and can ultimately lead to early admission to long-term care.

4. Scottish National Data

4.1. Number of people delayed

4.1.1. At the April 2025 census, there were 1,868 people delayed. Compared to the previous three census points, this is lower than March 2025 (1,925), February 2025 (1,986*)* and January 2025 (1,969).

4.2. Length of delay at census point

4.2.1. The average (median) length of delay for people delayed at the April 2025 census was 29 days. This is more than March 2025 (27 days), February 2025 (23 days) and January 2025 (22 days).

4.3. Average Number of beds occupied per day

4.3.1. The average number of beds occupied per day due to people delayed in hospital was 1,854 in April 2025. Compared to the previous three months, this is less than March 2025 (1,940), February 2025 (1,946) and January 2025 (1,964).

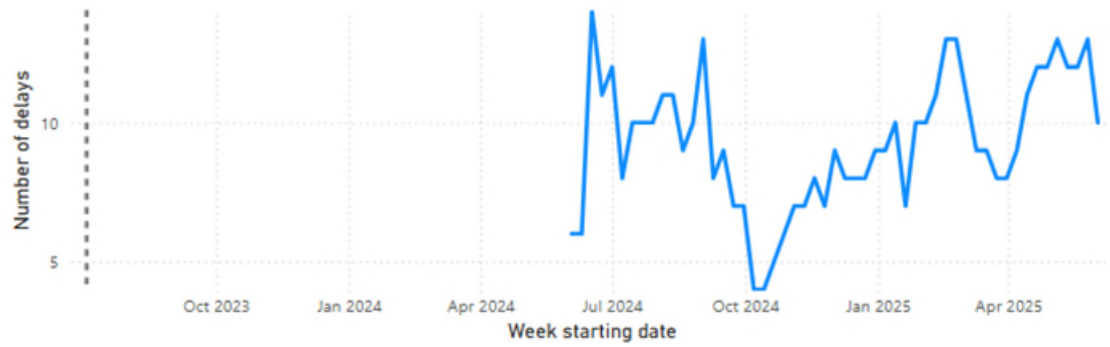
4.4. Delayed Days in Hospital

4.4.1. In April 2025, there were 55,620 days spent in hospital by people whose discharge was delayed. This is a decrease of 3% compared with the number of delayed days in April 2024 (57,433).

5. Current Orkney Position

5.1. As of 9 June 2025, there are:

- A total of 10 delayed transfers of care, equivalent to 26% of available in-patient care beds across In-patients 1 and In-patients 2 (excluding High Dependency Unit and Macmillan beds).
- Five delayed transfers of care awaiting residential care placement.
- Five delayed transfers of care awaiting Care at Home arrangements/package of care.



Orkney weekly data 03/06/24 – 02/06/25 (Figure 1).

Orkney delays for Adults with Incapacity (AWI) reasons (Code 9 AWI) (Figure 2).

5.2. 10 Delayed transfers of care equates to 70 occupied bed days per week, with 592 bed days occupied in total by those currently delayed to discharge.

5.3. The longest wait for residential care home placement was 16 weeks.

5.4. The longest wait for care at home provision was nine weeks.

6. Delay Codes 24A, 25D and 11B

6.1. 24A delay codes typically refer to reasons why a person is delayed from being discharged from a hospital or other healthcare setting, despite being medically ready to leave. These delays are often attributed to issues within social care arrangements, rather than the person's medical condition. Code 25D specifically points to a delay caused by the lack of available specialised facilities, which may be tailored to the needs of younger individuals and code 11B is used when a patient is clinically ready for discharge from hospital but is unable to leave because arrangements for post-discharge care, particularly social care, have not been finalised.

6.2. Inpatient procedure cancellations in last 12 months = 13 surgical procedures cancelled due to lack of inpatient bed capacity.

6.3. Implementation of surge capacity plan for acute services – utilisation of Day Case area as inpatient beds enacted twice in the last 12 months.

7. Day of Care Survey Findings – June 2024

7.1. The 'Day-of-Care Survey' tool was developed to assess inpatient delays in acute hospitals. Review teams, including social work, Allied Health Professions and key clinical staff, use case records and bedside charts to assess the patient's status against severity of illness and service intensity criteria. Patients who do not meet the survey criteria for acute care are identified and delays are categorised.

7.2. Orkney Care Of The Elderly (COTE) inpatients occupied 64% of the total bed complement, well above the Scotland average of 30%.

7.3. 35% of Orkney COTE inpatients did not meet the criteria to reside in an acute hospital.

7.4. Community capacity (care at home, residential placement), Allied Health Profession treatment and home environment suitability for rehabilitation needs were the top reasons for not meeting the criteria to reside.

7.5. As of 9 June 2025, 28 out of 35 occupied beds are COTE patients. 80% of all inpatients are over the age of 65 (average age 83 years), 35% of whom do not meet the criteria to reside, indicating that despite improvements in discharge planning, setting predicted day of discharge and early Multi-Disciplinary Team involvement the position in Orkney has not improved.

7.6. Care home occupancy remains high with 100% occupancy rates. The high rate of occupancy accompanied by the concurrent Large Scale Investigation at St Rognvald House contributes to the system wide pressures in placing those requiring residential care with long waits seen across the system, lack of respite availability impacting on carer health/resilience and social admissions to the acute sector and increased reliance on care at home support packages. Orkney is an outlier in terms of nursing care home beds with none currently provided.

7.7. Patients can often be delayed waiting for onwards care. For example, intermediate care services occupy an important middle ground between primary and hospital care for patients leaving hospital. These services include bed-based care, rehabilitation and reablement services, which often provide a much-needed ‘step-down’ service for people moving between more intensive hospital care and independent living or social care. However, recent reports suggest there is insufficient capacity to meet the demand for intermediate care, resulting in increased waiting times and delays in accessing this much-needed care both locally and nationally.

7.8. Agreeing that a patient is fit for discharge, as well as acquiring a care package and getting paperwork completed on time, can also be difficult. Assessments must be made of the additional support and care patients will need after leaving hospital, such as care workers providing support for daily activities, and installing handrails within patients’ homes to improve their safety and mobility. Delays can arise because a patient’s assessments are not planned and completed before they have recovered sufficiently to be discharged. Completing an early assessment of onward care needs generally requires agreement from a multidisciplinary group of acute clinicians, social

workers and other care workers. This can be a time-consuming and complex process.

7.9. Other factors can also come into play. These include disagreements between families/patients and providers concerning where the patient should be transferred; waiting for equipment to be installed in the community; awaiting public funding; and housing issues.

8. System Implications

8.1. When a patient no longer requires to remain in an acute hospital, they should be discharged home and their post hospital rehabilitation, care and support needs met by community health and care teams. If return home is not possible in the short term, they should transfer to a step-down bed in the community for a period of intermediate care and rehabilitation. Timely discharge from hospital is an important indicator of quality. It is a marker that care is person-centred, effective, integrated and harm-free.

8.2. Early planning and delivery on actions required to address delayed transfers of care will allow the Integration Joint Board and NHS Orkney to embed service change and review/consider new ways of working to support operational resilience. Key to this is understanding the local system and its functional capacity. Prevention and anticipation of demand on services will allow inconsistencies to be addressed and peak times of system challenge, whilst maximising capacity and service delivery in alignment with the national priorities set out in the NHS Scotland Operational Improvement Plan (OIP).

9. OIP Commitment – Shifting the Balance of Care

9.1. The commitment is to expand Hospital at Home, optimise community-based models, prevent avoidable admissions, and reduce delayed discharge.

9.2. The Orkney Health and Social Care Partnership and NHS Orkney's response:

- "We currently do not deliver a traditional Hospital at Home approach. Instead, our model reflects a rural and island-appropriate approach.
- Our priorities are focused on primary care transformation, local prescribing, virtual access, and integration with social care to enable people to remain safely at home and ambulatory care models.
- The Delivery Plan includes commitments to reduce inpatient stays, improve discharge processes (particularly for ferry-linked islands), and continue engagement with GIRFE to enhance anticipatory care and multi-agency working.
- Our Whole System Planning submission focused on those areas we currently require further investment to ensure sustainable service delivery specifically Comprehensive Geriatric Assessment, Home First principles of care and Front Door Frailty assessment to prevent admission. We are awaiting the outcome of this submission from Scottish Government."

10. Strategic Plan 2025 – 2028

10.1. One of the Strategic Priorities within the Strategic Plan 2025 – 2028 is 'Supporting People to Age Well'. This Strategic Priority contributes to the following National Health and Wellbeing Outcomes:

- Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer.
- Outcome 2: People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
- Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services.

10.2. Progress will be monitored against the Integration Indicators including the number of people being supported via Care at Home, the size of social work assessments waiting lists, and the number of people in hospital awaiting discharge who are delayed transfer of care.

10.3. Older people consistently advise that they would prefer to stay in their own homes, in their own communities, for as long as possible, rather than move into supported accommodation or residential care. To be more successful in meeting people's preference there needs to be an adequate workforce, who are appropriately remunerated and fully trained in the delivery of complex care through improving sheltered and residential care for our most frail and vulnerable older people.

10.4. The table below sets out the delivery Milestones for this Strategic Priority:

Delivery Milestones

Delivery Milestones Year 2025/26.	Measure.	Lead.	Timescale
Improve our preparedness for the analogue to digital switchover to ensure that our telecare services are fit for purpose.	We will increase the percentage of service users using digital from 26.5% to 60%.	Service Manager (Community Care). Head of Community Health and Care.	End of March 2026.
We will use projected need data to determine and agree the most appropriate use of the currently unutilised wing of Hamnavoe House.	A plan for how the fourth wing in Hamnavoe House will be commissioned, will be available with costings.	Head of Community Health and Care.	End of March 2026.
Individuals who are referred for a social work assessment will receive this in a timely manner	Reduce the outstanding social work assessments from 59 (as at 31/03/25) to 25.	Service Manager (Adult and Learning Disability Social Work). Head of Community Health and Care.	End of March 2026.
Further improve access to Care at Home provision.	Increase the number of service users in receipt of Care at Home by 5% from 171 (as at 31/03/25) to 180.	Service Manager (Community Care). Head of Community Health and Care.	End of March 2026.
We will continue to improve the quality of residential care provision in Orkney.	All Care Home Inspectorate Grades will be at Good or above.	Service Manager (Social Care). Head of Community Health and Care.	End of March 2026.

11. Action Summary

11.1. **Clinical Engagement:** Foster collaboration between healthcare professionals and patients to improve care outcomes and decision-making.

11.2. **Patient and Service User Engagement:** Involve patients, families, and service users in shaping services through feedback, co-design, and shared decision-making.

11.3. **Discharge Planning:** Co-ordinate timely and safe transitions from hospital to home or other care settings, ensuring continuity of care.

11.4. **Delayed Transfers of Care:** Identify and address barriers that prevent timely discharge, such as waiting for care packages or placements.

11.5. **Residential Care Homes:** Support quality of life and care standards in long-term residential facilities for individuals who cannot live independently.

11.6. **Nursing Care Homes:** Ensure access to skilled nursing care for residents with complex health needs in regulated care home environments.

11.7. **Care at Home:** Expand and personalise home-based care services to support independence and reduce hospital admissions.

11.8. **Technology:** Leverage digital tools (e.g., telehealth, electronic records) to enhance care delivery, communication, and monitoring.

11.9. **Recruitment:** Attract skilled professionals into the health and care workforce through targeted campaigns and incentives.

11.10. **Retention:** Improve staff satisfaction and reduce turnover through career development, wellbeing support, and recognition.

12. Contribution to quality

Please indicate which of the Orkney Community Plan 2025 to 2030 values are supported in this report adding Yes or No to the relevant area(s):

Resilience: To support and promote our strong communities.	Yes.
Enterprise: To tackle crosscutting issues such as digital connectivity, transport, housing and fuel poverty.	No.
Equality: To encourage services to provide equal opportunities for everyone.	Yes
Fairness: To make sure socio-economic and social factors are balanced.	Yes.
Innovation: To overcome issues more effectively through partnership working.	Yes.

Leadership: To involve partners such as community councils, community groups, voluntary groups and individuals in the process.	No.
Sustainability: To make sure economic and environmental factors are balanced.	Yes.

13. Resource and financial implications

13.1. At times of peak surge pressures or outbreak management, staffing available on site/across community and social care services is utilised to support increased capacity, this may require at times additional use of bank staff, overtime shifts and redeployment of staff from other roles to ensure patient safety across the system. Increased pressure will be seen on social care services to support delivery of Care at Home provision and bed capacity in the residential care homes noting the current challenges in recruitment and retention across these areas also.

13.2. The review of the utilisation and commissioning model for Hamnavoe House will have staffing and resource implications.

13.3. Care home bed provision, for example, Nursing bed capacity versus Residential Care, also requires scoping and may require staffing and resource allocation.

14. Risk, equality and climate change implications

14.1. Risks will be identified further through scoping exercise and mitigations understood and implemented.

14.2. There are no equality or climate change implications directly arising as a result of this report.

15. Direction required

Please indicate if this report requires a direction to be passed to:

NHS Orkney.	No.
Orkney Islands Council.	No.

16. Escalation required

Please indicate if this report requires escalated to:

NHS Orkney.	No.
Orkney Islands Council.	No.

17. Authors and contact information

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