Healthcare Improvement Scotland

Delayed Discharge – Adults with Incapacity

Learning report

May 2025

NHS SCOTLAND

May 2025

www.healthcareimprovementscotland.scot

The Scottish Government commissioned Healthcare Improvement Scotland to provide local support to three areas in Scotland (Glasgow City, Dumfries and Galloway, and Forth Valley) to reduce the Adults with Incapacity (AWI) delays in hospital discharge. This local support ran from July 2024 until June 2025.

This report summarises our learning about AWI hospital discharge delays to inform future action by others. The area of AWI has had a wide range of prior work to change, improve and respond to challenges. This report does not seek to provide a detailed description of this prior work. Instead, it covers our learning from our review of previous work, engagement with national and local stakeholders across Scotland, and our improvement work in Glasgow, Dumfries and Galloway and Forth Valley. This report is broken down into three chapters:

1. The impact of delays where AWI processes are relevant.
2. What drives delays where AWI processes are relevant?
3. What works to reduce delays where AWI processes are relevant?

Purpose

This report provides insight on the impact of factors that contribute to, and approaches that reduce delayed discharges where AWI is at play. It is intended to give national and local organisations insight into national and location action.

Who is this report for?

- Scottish Government when considering:
    - AWI policy, legislation and practice.
    - Support for and expectations on NHS boards, local authorities and Health and Social Care Partnerships (HSCPs) around hospital discharge planning and action on delayed discharge.
- Local NHS boards, HSCPs and local authorities when addressing delayed discharges – including funding, staffing, policies and procedures related to AWI discharge planning.

The findings from this report should be used to

- Inform local action on hospital discharge planning where AWI is at play
- Inform national legislation, policy and support for AWI.

1 The impact of delays where AWI processes are relevant

Delays in hospital discharge are longer for delays that involve AWI processes than for standard delays. The average delay where AWI processes are relevant in Glasgow is almost five times longer than the standard delay. 60% of Delays where AWI processes are relevant in Glasgow were delayed for more than 100 days. This section outlines the impact of delays where AWI processes are relevant to people and the health and social care system.

1.1 Impact on individuals

For individuals, lengthy stays in hospital have detrimental effects on both their mental and physical health. The evidence we have reviewed and gathered demonstrates that their lives in hospital do not represent the least restrictive option. Hospital settings struggle to put in place care and support that is the most beneficial to the individual, are often not able to align with the wishes of the adult and are not conducive to encouraging the adult to exercise skills that they do have – all of which are principles of the Adults with Incapacity (Scotland) Act 2000.

Common features of people's experience in hospital:

- Individuals are often confused and unaware of why they are in the hospital and why they are not allowed to leave. This can leave them repeatedly distressed.
- Individuals often have limited choices in the care they receive. This applies to how they spend their time, what they wear, and what and when they eat.
- Individuals often have very little access to the outdoors, spending most of their time in a chair or bed within a hospital ward. Where they have engaged family who visit often, they are more likely to be able to leave the ward for trips outside, usually on the hospital grounds or to a café based in the hospital. Due to resourcing constraints, staff time to take individuals outside and/or off the ward is uncommon.
- Individuals have very little privacy during their hospital stay, often in large multi-bedded wards separated only by curtains. The wards are noisy, and disagreements between patients or patients entering the space of other patients occur.
- Individuals can experience very little stability in their day-to-day lives, with staff and patient turnover occurring regularly, particularly in wards where many other patients have very short hospital stays.
- Individuals are at risk of hospital-acquired infections, such as COVID-19 and influenza. They are also at risk of increased hospital-induced dependency – reducing their mobility and their opportunities for independence during and after their hospital stays.

More details on the impact on people of their lengthy hospital delays can be found in the visual journeys we developed for Glasgow as part of this work.

1.2 Impact on the system

Delays in hospital discharge have a wide impact on the health and social care system. It increases hospital occupancy, thereby decreasing the number of beds available for other purposes. With delays where AWI processes are relevant much longer than the standard delay, a single person delayed where

AWI processes are relevant has a much higher impact on the system than a standard delay. Impacts of delayed discharges include:

- Cancelled surgeries - a greater number of beds used for delayed discharge increases the number of cancelled surgeries due to hospital bed capacity. In Glasgow, the average delays where AWI processes are relevant of 149 days is the equivalent to almost 80 cancelled surgeries or approximately five months' worth of all Glasgow surgeries cancelled due to hospital capacity challenges.[1] 40% of people see their health worsening while waiting for planned care[2]. Patient anxiety increases during the wait for surgery[3]. Combined, this increases the demand for primary and secondary care while waiting for surgery.[4]
- Increased Emergency Department (ED) waiting times – higher hospital occupancy rates result in longer wait times for people in the ED to be admitted.
    - This increases the risks to patients – for example, for every 82 admitted patients who were delayed eight or more hours in ED, there is one extra death.[5]
    - This increases the waiting times for everyone in the ED as they struggle to create flow through the department. Every 1% increase in bed occupancy decreases the probability of meeting the ED four hour wait target by 9.5%.[6] Waiting times in the ED of more than five hours increase the 30-day mortality rate.[7]
- Ambulance delays – delays in the ED lead to delays in ambulances able to hand over patients from their care to the care of the ED. 20% of ambulance capacity is estimated to be lost from delayed handovers[8], leading to the stacking of ambulances outside the hospital[9][10]. Delays in handover increase potential harm to patients – 9% experience potential additional harm, and 1% experience potential severe harm from handover delays of more than one hour.[11] As ambulances wait outside hospitals, the capacity to respond to the need in the community reduces, creating additional risk of harm of others.

[1] A combination of data from Glasgow HSCP hospital based social work team on AWI delays between October 2023 and January 2025 and Glasgow specific data from PHS on cancelled planned operations and episodes and spells data from July 2019 to September 2024 accessed at https://www.opendata.nhs.scot/dataset/479848ef-41f8-44c5-bfb5-666e0df8f574/resource/0f1cf6b1-ebf6-4928-b490-0a721cc98884 and https://www.opendata.nhs.scot/dataset/d73b93ab-b09f-4d39-9cfb-0e5e34085803/resource/d59528c3-0a61-4fdd-8ed9-f6822838c78c

[2] Care Quality Commission: Majority of patients remain positive about care they receive when in hospital but over a third say their health deteriorated while waiting for treatment – available at: Majority of patients remain positive about care they receive when in hospital but over a third say their health deteriorated while waiting for treatment - Care Quality Commission

[3] BMC Public Health: Waiting for elective general surgery: impact on health related quality of life and psychosocial consequences – available at: Waiting for elective general surgery: impact on health related quality of life and psychosocial consequences - PMC

[4] BMC Health Service Research: The cost of keeping patients waiting: retrospective treatment-control study of additional healthcare utilisation for UK patients awaiting elective treatment – available at: The cost of keeping patients waiting: retrospective treatment-control study of additional healthcare utilisation for UK patients awaiting elective treatment | BMC Health Services Research | Full Text

[5] Increased Mortality From A&E Waits Over 5 Hours
- available at https://www.medscape.co.uk/viewarticle/increased-mortality-a-e-waits-over-5-hours-2022a10005ib

[6] Spill Over Effects of Inpatient Bed Capacity on Accident and Emergency Performance in England - ScienceDirect

[7] Increased Mortality From A&E Waits Over 5 Hours
- available at https://www.medscape.co.uk/viewarticle/increased-mortality-a-e-waits-over-5-hours-2022a10005ib

[8] Health Foundation: Why have ambulance waiting times been getting worse? Refers to UK wide data for July 2022 – available at: Why have ambulance waiting times been getting worse? - The Health Foundation

[9] Health Foundation: Why have ambulance waiting times been getting worse? Refers to UK wide data for July 2022 – available at: Why have ambulance waiting times been getting worse? - The Health Foundation

[10] Nuffield Trust: Ambulance handover delays – available at: Ambulance handover delays | Nuffield Trust

[11] Nuffield Trust: Ambulance handover delays – available at: Ambulance handover delays | Nuffield Trust

2 What drives AWI delays

This section outlines our observations on what drives delays where AWI processes are relevant. These insights are drawn from prior work in the area, our engagement with national and local stakeholders, and our improvement work in the three local areas.

2.1 Who tends to get delayed?

Delays where AWI processes are relevant cover anyone where the individual has been assessed as not having the capacity to make decisions about the care required to support their discharge from the hospital[12] and the appropriate powers are not already in place through Powers of Attorney or a Guardianship Order. From our work, delays where AWI processes are relevant, seem common amongst older frail older adults with underlying health conditions affecting their capacity and younger adults who have complex lives that may include the mental and physical effects of long periods of drug or alcohol use – for example, Alcohol Related Brain Damage and liver conditions.

2.2 What can delay discharge?

Based on our work, the following areas are common reasons for delay.

- Delays can be longer when disagreements arise between health and social care staff and the individual or their families. This is particularly true when the individual or relevant others raise objections during Sheriff Court hearings, leading to lengthy or repeated continuances.
- For private guardianship applications, delays can be common when the applicant and/or their solicitor are not proactive in progressing through the stages required to lodge an application in court that meets the Sheriff's requirements.
- For people with complex care needs, particularly younger adults, delays can arise when finding a suitable care placement.
- Coordination between staff, staff capacity, and staff absence management is inefficient, leading to delays at various stages, such as arranging case conferences, assessing capacity, completing medical reports, and completing the casework required to complete Mental Health Officer (MHO) reports.
- Confusion, misunderstanding and mistruths about the legal requirements and how they influence practice across all professions involved in the process. This can lead to more risk-averse interpretations, conservative rules of thumb being implemented, miscommunications between staff, and delayed or inaccurate activity.
- Other priorities can overshadow activities necessary for AWI legislative requirements. This is particularly true for social workers and mental health officers with competing legislative functions under the Mental Health Act and large caseloads across community and inpatient settings.

  There may be a view that those in the hospital are safe and, therefore, at less risk than those being supported in the community – for example, about adult support and protection concerns.

From our local work, engagement, and review of prior activity, the following are important factors in the context of delays where AWI processes are relevant:

[12] for example moving into residential care or having their access to particular individuals or substances managed

- Efficient AWI discharge planning relies on effective coordinated action across ward staff, mental health officers, social work, and legal teams. Strong relationships and agreed operating procedures that govern interactions between professionals are vital to helping coordinate action. We are seeing challenges where fragmented action leads to multiple handover points between professions, with no one proactively managing its coordination or holding responsibility for the overall pace. An example is where professions have operating procedures that govern their part of the process. However, these operating procedures do not effectively connect with others who share a common understanding of who does what, when, and why across professions.
- There are systemic barriers to improving the pace of discharge that require national action to enable local improvement. This includes but is not limited to legislative review. The current legislation has an inherent tension built into it that local areas cannot move away from. Legal authority is not required to admit someone to a hospital, but it is necessary to support a move to residential care. The legal barrier to admission, combined with a high barrier for hospital discharge, traps people in hospital for lengthy periods in settings not designed to meet their needs. Local areas are limited in their ability to make a balanced decision on the least restrictive option for the individual by the current legislative framework.
- Local areas have very little influence over the speed of private applications. They are reliant on the proactiveness of the applicant and their solicitor. Local areas can only apply themselves if they are confident that no other person has or is likely to lodge an application in Court for guardianship.
- Powers of Attorney (POA), with the required power to support decisions about a person's discharge, means that someone is not delayed where AWI processes are relevant. This preventative action faces several barriers that limit the effectiveness of generic awareness-raising campaigns.
    - Using a solicitor to put in place POA is expensive and takes time and energy to do. These pose challenges for more deprived communities, where the cost is a barrier and the priority of POA is lower than other, more pressing challenges. The current process in Scotland is challenging to navigate, so people tend to use solicitors for POA far more than they do in some other UK jurisdictions.
    - POA need to include the appropriate powers to approve a move into residential care and implement care arrangements that may represent a deprivation of liberty. Confusion can occur when a POA is in place but does not include the necessary powers to support hospital discharge upon examination. POAs that include powers to deprive someone of their liberty may require more review and monitoring than they currently do, similar to the process for Guardianship orders.
- National and local decision-making tends to focus on the changes needed in various parts of the technical process. What we have found is often missing from these discussions is the impact of the whole process on the individual. This is why we developed the visual journeys of people's experiences in hospital. Shifting the nature of the discussion amongst decision makers helps examine the overall drivers of harm and risk to individuals.

3 What works to reduce AWI delays

This section outlines our observations on what works to reduce delays where AWI processes are relevant. The key things covered in this section are

1. Active management of AWI discharge planning.
2. The presence of preventative systems that reduce admissions, reduce duration of admissions, reduce the need for care homes, and prioritise the efficient discharge from the hospital.
3. Creating room for staff from across settings and professions to come together to think differently.
4. Prioritising and valuing the development of relationships needed for joint and integrated action.
5. Widening the sources of insight and evidence we draw on to make decisions.
6. Change the nature of the pressure we put on local areas by changing the way we fund and measure.
7. Developing the right combination of leadership skills is needed.

3.1 Management of discharge planning

Active management of the AWI discharge planning process to maximise the efficiency of processes within the current legal framework. The effectiveness of coordination between social workers, mental health officers and hospital teams is vital for reducing delays where AWI processes are relevant. Examples of where we have seen this work well include:

- Where social workers and mental health officers are embedded within integrated flow and discharge teams in hospitals. This enables strong relationships between social workers and clinical staff who need to agree on and coordinate joint actions. It provides more opportunities for social workers to engage directly with individuals and their families.
- Where hospital-based social workers can assess needs and arrange care across all local authority areas that the hospital covers. Hospital-based social workers can assess needs and line up care arrangements across the local authority areas that the hospital covers. For example, social workers within Dundee hospitals can assess and put in place care for people with Perth and Kinross or Angus postcodes.
- The willingness to set timeframes for private guardians to make reasonable progress before local authority guardianship is pursued is implemented with the appropriate reasonable adjustments by social work staff.
- Clear and agreed standard operating procedures that govern how different professions work together during the AWI process.
- Staff resources to track and manage the progress of AWI processes to coordinate the various professions, private solicitors, family and relevant others.
- Staff resource and willingness to have difficult conversations with family about guardianship processes to keep momentum going.

A sustained multi-year investment in Mental Health Officer training is required to meet the demand for Mental Health Officer capacity in the system. Without it, recruitment of Mental Health Officers risks seeing posts filled by staff moving from one geography to another, thereby moving the existing workforce challenges around Scotland. Stable and secure funding over multiple years that focuses on

increasing the number of Mental Health Officers trained is needed to meet the capacity required for efficient AWI discharge planning.

3.2 Preventative systems

Preventive systems effectively and efficiently pull people from the hospital into community settings. Preventive systems have two core features:

- Recognition that to address our systemic challenges in health and social care, the ability of each service or part of the system to 'solve its problems is limited. Effective solutions are likely to require action across multiple parts of the system. This means that we need to look broader when considering improvement opportunities. Changes in one part of the system are likely to impact a wide range of other parts of the system. This means that we need to look more broadly when considering the intended and unintended consequences of the changes we are considering.
- Recognition that prevention is not just about investing in particular 'preventative initiatives'. It is also about how we arrange the different parts of our system to enable a preventative effect from how the parts of the system interact with each other.

In the context of delays where AWI processes are relevant, the following kinds of prevention are needed:

1. **Avoiding people being admitted to hospital** through the ability to provide the care and support required within community and outpatient settings. Preventing hospital admission is particularly important amongst the AWI cohort, as the barriers to discharge are high if the appropriate legal authority is not already in place. The mechanisms for avoiding admission are the same for the AWI cohort as for the general population.

However, two features of avoiding admission are significant for the AWI cohort:

- For young adults with complex needs and incapacity, it is imperative to invest in preventing the breakdown of their current housing in the community, so keeping people in their tenancy or the supported accommodation becomes important. Delays in hospital discharge can occur due to the time it takes to find appropriate residential care for individuals with complex care needs.
- Older adults with frailty and incapacity – time in hospital for this group is closely linked to reduced independence from cognitive and physical decline. This decline increases the chance that they need to move into residential care rather than return home with a support package. It also increases the level of care required to support a move to home, which may or may not need legal powers to implement.

2. **Reducing the number of people needing residential care following their hospital stay** through effective reablement, discharge-to-assess, and reducing hospital-induced dependency. Legal powers are generally not required to discharge someone home with a care package. There may be times when a planned care package requires the use of legal powers, for example, if it involves depriving an individual of their liberty. We can reduce the number of delays waiting for a guardianship process to be completed by reducing the number of people discharged from hospital to residential care.

The following are features of an effective preventative system for reducing delayed discharge, including delays where AWI processes are relevant.

- Effective coordinated care for **people to stay in their home during periods of acute health** need means fewer people are admitted into hospital in the first place, which reduces the number of people who are delayed in hospital (especially for AWI, as you do not need legal powers to keep someone in their home).
    - We have seen this work well, including multidisciplinary community health teams comprising nursing, Allied Health Professions (AHPs), and consultants who can effectively identify and provide care to prevent hospital admissions.
    - They become aware of individuals through various staff raising concerns, including General Practitioners (GPs), care at home staff, and staff at the hospital's front door who want an alternative to admitting the patient.
    - One example of this working well is the support that geriatricians provide to hospital wards and multidisciplinary community health teams. This meant continuity of care for older people as the same staff team knows the person well, leading to less risk-averse decisions and greater comfort with patients being cared for at home.
- Well-functioning **Discharge to Assess or Home First** models are used when someone is discharged with a temporary package of care back to their home to be assessed within their own home. Where Discharge to Assess teams work closely with hospital discharge teams, we see greater success in their ability to manage the fixed Discharge to Assess resources and maximise the number of people they can support. This relationship becomes more transactional when the Discharge to Assess team is only supported by referrals from hospital teams. It can struggle to adapt the Discharge to Assess resources to maximise its impact.
- Without **sufficient Care at Home provision,** other interventions that aim to enable people to be timely discharged from hospital (such as rehabilitation, reablement and discharge to assess) become backlogged – unable to move people onto Care at Home, which means they cannot continually take new patients from hospital.
    - Examples of where Care at Home provision has been increased show that increasing wages, paying for full shifts, and creating better working conditions enable them to tackle the recruitment challenges that affect the supply of Care at Home.
    - Where effective reablement, rehabilitation, and discharge are needed to assess services in place, we find lower long-term Care at Home packages required, which helps manage ongoing increases in demand for Care at Home.
- Access to **reablement, rehabilitation and independent living** support to enable more people to be discharged home with reablement in mind and to reduce the overall demand on residential and non-residential social care, which reduces the impact of unmanageable demand for other services, restricting timely discharge from hospital.
- Effective **support 'at the front door'** of urgent care to support people without the need to admit to a hospital, reduce the need to take someone to hospital, and minimise the length of hospital stay for those admitted – this includes at hospitals, with Police Scotland, and with Scottish Ambulance Service all of whom are likely to come into contact with people first.

- Where commissioning follows **good practice in commissioning** (for example, ethical commissioning practices), we see a greater ability for the resource to flex and adapt to the needs of people and better address workforce challenges. Trust leads to flexibility and tailored support to get people home

3.3 Spaces to think differently

Create opportunities for staff from across professions to set up spaces to think differently about how they tackle problems, help to identify and implement change ideas that make a difference for people and staff. The staff we engaged with in these spaces reported that it helped build excitement and reduce the feeling of powerlessness in the context of what feels like relentless demands and firefighting in their day-to-day roles. Critical to these spaces is

- Multi-disciplinary and multi-setting participation to enable staff to understand each other better, build relationships, and identify changes needed in the way processes and staff interact with one another rather than in isolation from other parts of the system.
- Regular established spaces that are not entirely reliant on one-off events or programme specific spaces that disappear when the programme is over.
- Meaningful engagement by senior leaders on challenges and ideas explored by staff.

3.4 Valuing relationship for joint action

Critical to integration and joint action are the strength and breadth of staff relationships across settings and professions. Strong relationships enable joint problem-solving, collaborative creation of new insights, and a more consistent ethos and commitment. Participants from our local work reported that by building relationships with other teams and professions, they:

- Had a better understanding of other professions, their priorities, their pressures and their role, which enabled them to interact with each other with more empathy and bond over shared experiences and challenges
- Were better able to solve day-to-day challenges or delays more quickly, as they knew whom to contact for a quick chat to get advice or agreement, rather than relying on formal processes that felt more transactional for things that did not need the formal process to be solved.
- Better understood each other's processes and requirements, meaning they could pre-empt activity or identify challenges earlier for things that would need to happen later. For example, nursing staff actioned concerns around capacity earlier and provided more information to social workers during the referral to make their processes easier.

3.5 Widening source of insight

A single source of output and throughput quantitative data is limited in what it can reveal about the nature of delays where AWI processes are relevant in an area and is even more limited in what it can suggest for addressing them. Where we prioritise bringing in additional insights and evidence sources to prevent us from reading quantitative management data in isolation, it improves the decisions and the type of pressure that we put nationally on local action.

3.6 Changing the nature of national and local pressure

From our national and local engagement, we have noticed a prioritisation of 'any action as long as it is now' over 'appropriately considering action that will address the problem'. The signalling that national bodies send regarding what we prioritise in decision-making is felt by local leaders all the way through to delivery teams.

How we fund also contributes to the nature of decisions made at national and local levels. Multiple rounds of short-term funding can result in patchy and short-lived changes that undermine staff buy-in to change. Change requires significant investment in staff time and energy. We have noticed that short-term funding for interim changes can lead to staff disengagement in change processes as they struggle to find the energy to continually invest in change that they feel will not have a lasting impact on people and staff.

3.7 Leadership skills

Leadership is regularly discussed in the context of effective improvement. Within delays where AWI processes are relevant, we have observed that leaders' knowledge, influence, and persistence are fundamental to seeing sustained and effective change.

- Strong knowledge of social work, acute settings, social care, and the relevant legal frameworks underpinning these areas to be able to see the process from each profession's perspective to dispel myths or misconceptions and make decisions that are not overly risk averse.
- The ability to articulate and defend the rationale behind decisions but be open to change when alternative courses of action hold weight. This is particularly important for AWI delays, where there is a risk that each profession has its own tightly held opinion that conflicts with the positions of other professions.
- Constructively able to challenge views held by people and families by understanding their priorities, values, and concerns. This is particularly important when motivating rapid action on private applications or addressing disagreement that may prevent the use of section 13ZA.
- Able to foster and harness the appetite for change in others to build momentum for change across the wider system. This is particularly important given the wide range of professions involved in AWI delays and the extent to which delays are driven by actions in other parts of the health and social care system (for example, social care, primary community care)
- Comfort in making quality decisions in the face of uncertainty. Delays where AWI processes are relevant rely on action across the system and are impacted by decisions made in other parts of the system. The system's reaction to changes cannot be easily predicted. Making decisions, holding their nerve, and adapting accordingly are critical in the context of leadership regarding delays where AWI processes are relevant.

May 2025

You can read and download this document from our website.
We are happy to consider requests for other languages or formats.
Please contact our Equality and Diversity Advisor on 0141 225 6999
or email his.contactpublicinvolvement@nhs.scot

Healthcare Improvement Scotland

Edinburgh Office
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

Glasgow Office
Delta House
50 West Nile Street
Glasgow
G1 2NP

0141 225 6999

www.healthcareimprovementscotland.scot