Reducing delays in hospital discharge for people: the potential of the not-for-profit social care sector

CCPS Report – August 2026

CCPS

COALITION OF CARE AND SUPPORT PROVIDERS IN SCOTLAND

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Foreword

At the Coalition of Care and Support Providers in Scotland (CCPS), we work with our not-for-profit provider members to deliver on our vision: that individuals, families and communities can thrive with the support of a rights-based, sustainable system of care and support.

Our members provide support for a wide range of people with diverse needs across all of Scotland, including older people; children, young people and families; disabled people; people experiencing poor mental health; people living with alcohol or drug dependence; people with dementia; neurodivergent people; survivors of domestic abuse; people experiencing homelessness or insecure housing; and people involved with the justice system. Many of the people supported by CCPS members will have regular, sometimes frequent, contact with our NHS. And many will face unnecessary hospital admission or delays in discharge because insufficient social care and support is available to keep them well and independent in their communities.

In her speech to the Scottish Parliament when presenting the draft Scottish Budget for 2026-27 – and shortly after an Audit Scotland report estimated that £440m of public funds a year is wasted on delayed discharges[1] – the former Cabinet Secretary for Finance, Shona Robison, stated that: "today's budget will enable further action to reduce delayed discharges as the Health Secretary will set out following engagement with local government and health and social care partners."

Since the Scottish Budget announcement, CCPS has taken part in some emerging national discussion on how to improve people's outcomes when they engage with health and social care services. But there is so much more to do to turn around experiences and outcomes for those people who simply should not be in hospital.

This short paper focuses on why our sector is **critical** to the success of reducing delays in people's discharge. It is just one example of how commissioned social care providers could deliver so much more for the government, and our families and neighbours, in the reform of public services.

However, the experiences of CCPS members shared in writing this report demonstrate that barriers – rooted in commissioning, funding and planning systems that are not fit for purpose – are significantly constraining their ability to contribute effectively to people's timely and successful hospital discharge. Our case studies also show what *is* possible when these barriers are overcome.

The First Minister has committed to developing "a new national plan for hospital flow to ease pressures in A&E and address delays in discharge." We hope that plan will prioritise how to improve people's outcomes and uphold their rights rather than focus on the system. CCPS members have the expertise, experience and commitment to help design and deliver just that with others. So, we look forward to being core partners in a programme of much needed change for people who need support to flourish.

Rachel Cackett
CEO, CCPS

[1] Delayed discharges: A symptom of the challenges facing health and social care | Audit Scotland

The Current Reality of Delays to People's Hospital Discharge

Despite being clinically ready, many people remain in hospital due to gaps or barriers in community care, housing, commissioning and planning systems. CCPS members consistently describe delays in people's hospital discharge not as an isolated or individual issue, but as a structural problem which emerges at the interface of health, social care and housing.

Public Health Scotland data continues to show that delays are frequently associated with the availability and completion of care arrangements, places and community care assessments. This underlines that the issue is rooted in system capacity and coordination, with these constraints often reflecting upstream funding, commissioning and planning failures.

The latest full-year data available, for 2025/26, shows that people delayed in their discharge spent 705,952 days in hospital. This was 2% lower than the record 720,119 days recorded in 2024/25 but remained substantially above the 666,190 days recorded in 2023/24 and the 542,204 days recorded in 2019/20. In 2025/26, an average of 1,934 hospital beds per day were occupied by people delayed in their discharge.[2]

Delays are costly to the NHS. As already noted, a recent report from Audit Scotland[3] found that people medically ready to leave hospital but delayed in discharge cost "…an estimated £440 million a year". This is public money that could be better invested.

But at a human level these delays are also significantly detrimental to people's dignity, independence and health outcomes.

This is further reinforced by the Coming Home Action Plan,[4] published in March 2026, which highlights the actions needed to address the long-standing and profound human impact of extended hospital stays for people with learning disabilities and complex needs.

Financial and Commissioning Barriers

CCPS members consistently report that contracts to deliver social care neither cover the true cost of services, nor allow them to meet need. In the first half of 2025-26, almost half of respondents to a CCPS survey told us they'd had to make service reductions, negatively impacting an estimated 4,645 beneficiaries. Over 40% were anticipating reducing support in the second half of the year, impacting an estimated 3,858 beneficiaries. Over half of respondents were already using reserves to reach financial balance by the mid-point of 2025-26.[5]

In addition to insufficient funding, the default commissioning model for social care effectively guarantees no spare capacity. In practice, this means providers are not resourced to maintain unused

[2] Delayed discharges in NHS Scotland annual - summary of occupied bed days and census figures: Data to March 2026 - Delayed discharges in NHS Scotland annual - Publications - Public Health Scotland
[3] Ibid.
[4] Coming Home Action Plan 2026 - gov.scot
[5] CCPS-Briefing-Stage-3-Fund-Social-Care-Like-It-Matters.pdf

capacity between care packages, limiting their ability to respond immediately when people are ready for discharge. In many areas, funding for a person's social care package simply stops immediately upon hospital admission, undermining continuity and delaying readiness for discharge.

Members also report a lack of joined-up decision making, where services that could contribute to realising the national commitment to reduce the number of people delayed in their discharge from hospital are instead subject to reduction or redesign, further weakening community capacity.

Capacity Constraints as a Design Issue

Providers highlight that capacity challenges are often shaped by how services are planned and funded:

- Providers cannot hold unallocated staff capacity without guaranteed funding.
- Even where workers are available, commissioning lacks the flexibility to deploy them responsively.
- A lack of care management capacity further slows safe discharge.

Inequities in pay, terms and conditions across the wider health and care system continue to affect commissioned social care providers' ability to recruit and retain staff, reinforcing pressures created by wider commissioning design.

These factors combine to make delays a predictable outcome of systemic design decisions, rather than isolated operational challenges.

Fragmentation, Culture and Practice Variation

Accessible and suitable housing is central to discharge planning. Members consistently cite:

- Shortages of adaptable, accessible homes.
- Late engagement of housing partners in discharge planning.
- Housing design standards that fail to meet people's needs.

Housing is often treated as a downstream issue rather than a core part of a discharge pathway, leading to preventable delays, creating tensions within the system which risk leaving people in hospital unnecessarily.

Experiences of people's discharge from hospital vary significantly across local areas, risking unequal outcomes. In some places, strong personal relationships enable effective collaboration; elsewhere, cultural and structural barriers between sectors undermine cohesive planning.

Providers often report being excluded from key planning discussions despite their operational expertise and core delivery role, with local processes highly dependent on individual commitment rather than consistent system design.

Practice Evidence – What Works in Reality

The case studies at **Appendix A** show how not-for-profit providers of social care and support can help improve discharge outcomes for people, with public sector partners, when system conditions allow. These include practice from providers demonstrating:

- Early involvement of support and housing partners in planning.
- Phased, readiness-based transitions instead of fixed discharge deadlines.
- Discharge-to-assess approaches and home-based assessments.
- Needs-led, flexible funding rather than rigid packages.
- Integrated multidisciplinary teams across health, social care and housing.
- Trauma-informed, person-centred approaches.

Collectively, these examples demonstrate how these approaches can support timely discharge and improve experiences for people and families.

What This Evidence Tells Us About the System

Social care and support already hold many of the solutions to delayed discharge – for both people and our wider public service system. The primary barriers are not provider capability or willingness, but rather systemic design – how services are commissioned, how capacity is funded, who is involved in planning, and when.

System design also affects the sector's ability to recruit and retain skilled staff on equitable terms across the wider health and care landscape.

Investment that improves in-hospital flow without parallel support for community capacity will not sustainably resolve delayed discharge. Enabling stability, flexibility and early planning in social care can support better outcomes and make more effective use of public resources.

Whole-system planning, aligned with prevention priorities, is critical. Avoiding unnecessary admission – and indeed readmission – is key both to reducing NHS pressures and to achieving better outcomes for people. Strengthening community capacity is therefore not only about discharge, but about prevention and sustainability across the system.

Taking this approach would have enormous benefit for people in Scotland who are too often let down by a system still not designed and funded to support them to flourish in their own homes and communities.

Context from the 2026-27 Scottish Budget

During the passage of the 2026-27 Scottish Government Budget, ministers committed to "further action to reduce delayed discharges", with the then-Cabinet Secretary for Health expected to set out further detail following engagement with local government and health and social care partners.[6]

The Scottish Spending Review also identifies increased community capacity as important to improving delayed discharge and A&E performance.[7] CCPS and its members should be critical partners in ensuring investment is directed to strengthen community capacity and improve outcomes. Early provider involvement will be essential to support:

- More flexible commissioning models that allow social care to respond to real-time needs.
- Stable funding that delivers full cost recovery, recognising inflationary pressures, and reflecting the real value of a skilled social care workforce.
- Earlier, consistent involvement of providers and housing partners in discharge planning and implementation.
- Recognition of social care and support providers as equal system partners in designing and delivering better public services for Scotland's people.

Concluding Thoughts

Social care providers want to play a central role in enabling timely, safe and sustainable discharge from hospital. Across Scotland, members are already demonstrating what is possible when social care is involved early, funded flexibly and treated as an equal system partner. The challenge is not a lack of willingness, expertise or innovation among providers, but a system that too often prevents effective solutions from being deployed at scale.

CCPS stands ready to work with government, local authorities, NHS leaders and, most importantly, people supported by health and social care services – alongside their families and unpaid carers – to help design and deliver the system changes needed. Delayed discharge is not inevitable; it reflects how the system is currently structured, and that structure can be changed through genuine partnership.

[6] Scottish Budget 2026-2027: Finance Secretary's statement - 13 January 2026 - gov.scot
[7] Annex B: Portfolio Efficiency and Reform Plans - Scottish Spending Review 2026 - gov.scot

APPENDIX A: Improving Delays in Hospital Discharge for People: Examples from CCPS members on what works

Case Study 1: Carr Gomm – Flexible Community Support Reducing Delayed Discharge and Admissions [8]

Context

Carr Gomm delivers community-based social care services supporting people with varied needs, including complex needs, across urban, rural and island communities. The services, which include mental health support, frequently support people at risk of delayed discharge or repeat hospital admission due to limited community capacity and fragmented discharge planning.

The Approach

Carr Gomm operates flexible, preventative and discharge-enabling services designed to respond in real time rather than through fixed care packages. Key elements of this approach include:

- Early engagement with NHS, social work and HSCP colleagues when admission risk emerges.
- Rapid mobilisation of support to stabilise people in the community or prepare for discharge.
- Capacity to flex support intensity up or down according to need.
- Close multidisciplinary working with health professionals and care managers.

What Enabled Success

- Flexible services achieved through sustainable funding, allowing capacity to be rebalanced rather than rationed.
- Strong, trust-based relationships with statutory partners.
- Workforce models designed for responsiveness rather than static allocation, allowing capacity to be deployed where and when it is most needed.
- Recognition of social care as both a preventative service and a critical component of hospital flow, by local partners and commissioners.

Impact

- Reduced delayed discharge once individuals were clinically ready to leave.
- Fewer avoidable or repeat hospital admissions.
- Improved continuity, experience and outcomes for people supported.
- More effective use of public resources by reducing reliance on inpatient care.

Key Learning

Carr Gomm's experience demonstrates how flexibly funded, responsive community social care can play a critical role in supporting timely discharge and preventing avoidable admissions. It highlights the value of designing services around people's changing needs, with the ability to adjust support quickly and work collaboratively across systems to deliver better outcomes.

[8] *Despite the recognised effectiveness of one of Carr Gomm's preventative services, the respective HSCP proposed to cut this service at the start of 2026 as a budget-saving measure. Although funding was eventually maintained, it illustrates the ongoing potential of disconnect between national strategy and local investment choices.*

Case Study 2: Ark Housing – Planned Discharge Following a Prolonged Hospital Stay

Context

Ark Housing supported the discharge of a person with a learning disability and complex trauma following a prolonged period in hospital as a delayed discharge patient. Previous discharge attempts had stalled due to housing challenges, risk concerns and fragmented planning.

The Approach

Ark Housing worked with partners to develop a planned, phased and trauma-informed transition from hospital into the community. This included:

- Early identification of appropriate housing.
- Environmental adaptations to ensure the property met the individual's needs.
- Gradual familiarisation with the new home prior to discharge.
- Consistent staffing to build trust and reduce distress.
- Shared decision-making and collective ownership of risk across agencies.

What Enabled Success

- Time and flexibility built into planning, rather than pressure to meet fixed discharge deadlines.
- Sustained involvement of Ark throughout the hospital stay.
- Clear communication between health, social work and housing partners.
- Recognition that readiness and stability were more important than speed alone.

Impact

- A successful move from hospital into the community after years of delayed discharge.
- Improved wellbeing, independence and quality of life for the individual.
- Long-term community stability with reduced reliance on inpatient services.

Key Learning

This case study highlights the importance of early housing solutions, phased transitions and trauma-informed social care – all system enablers identified in the CCPS report as critical to addressing delayed discharge.

Case Study 3: Key – Supporting New Routes Home and the 'Coming Home' Toolkits

Context

New Routes Home is a national initiative coordinated by In Control Scotland, bringing together people with lived experience, family carers and professionals across health, social care and housing to improve how people return home. The programme responds to challenges including fragmented planning, unclear roles and avoidable delays. This summary is based on partner contributions and should be considered alongside their own published materials.

CCPS member, Key, is a participating organisation in New Routes Home, contributing to efforts to improve outcomes for people with complex needs who have experienced long delays in returning to community settings, highlighted in the Coming Home report.

The Approach

In Control Scotland led the development of the 'Coming Home' toolkits through a co-production process involving people with lived experience, providers and cross-sector partners.

Key's contribution included:

- Participation in national working groups shaping the toolkits.
- Supporting collaborative learning and shared development.
- Hosting the national launch event for the toolkits.

The toolkits are designed to support:

- Earlier, person-centred discharge planning.
- Clearer shared roles and accountability across agencies.
- Better communication with individuals and families.
- Stronger collaboration between health, housing and social care.

What Enabled Success

- National coordination and leadership from In Control Scotland.
- Genuine co-production with lived experience.
- Cross-sector participation and shared ownership.
- Practical tools designed for local adaptation.

Impact

- Improved shared understanding of discharge pathways.
- Greater clarity about responsibilities across agencies.
- Stronger foundations for earlier, more coordinated planning.

Key Learning

This work demonstrates how national coordination, co-production and shared tools can help address systemic fragmentation in discharge pathways. It also highlights the value of member organisations actively contributing to sector-wide improvement, even where they are not the lead body.

Case Study 4: British Red Cross – Discharge to Assess

Context

British Red Cross works alongside NHS and health and social care partners to support people who are medically ready to leave hospital but require practical and emotional support to return home safely. Their services focus on preventing delayed discharge and reducing avoidable readmissions.

The Approach

Red Cross delivers person-centred discharge and short-term home support through models such as Discharge to Assess/Home to Assess. This includes:

- Practical help to settle safely at home.
- Short-term, home-based assessment and support.
- Emotional support and connection to community services.
- Assessment and recovery take place in the person's own home rather than in hospital, ensuring support reflects real-life needs and circumstances.

What Enabled Success

- Close integration with hospital discharge teams.
- Flexible, short-term support tailored to individual need, following an enablement approach.
- Strong cross-sector partnership working.
- Recognition of practical and social needs as critical to safe discharge.

Impact

- Earlier, safer discharge from hospital.
- Reduced risk of avoidable readmission.
- Increased independence and confidence at home.
- Improved patient flow within acute services.
- Reduced pressure on social care.

Key Learning

The Red Cross model demonstrates that when practical, emotional and short-term recovery support is embedded within discharge pathways, hospital stays can be reduced without compromising safety. Moving assessment into the home supports better outcomes for individuals and the wider system.

Bringing the Learning Together

Together, these case studies demonstrate that not-for-profit social care providers, and national partners, are already delivering practical solutions to delayed discharge.

Across the examples, several common themes emerge:

- Early and sustained social care provider involvement improves discharge flow and reduces crisis-driven decision-making.
- Flexible, person-centred models support safer and more sustainable transitions home.
- Cross-sector collaboration – including housing, health, social care and the voluntary sector – is essential.
- National coordination and shared tools, as demonstrated by In Control Scotland's leadership of New Routes Home, help address structural fragmentation and create common language and expectations across the system.

These examples reinforce the central conclusion of the CCPS delayed discharge report: delayed discharge is not an inevitable feature of the system, but a consequence of how the system is designed – and one that can be changed through earlier planning, flexible community capacity, shared accountability and genuine partnership working.

If you have any follow-up questions to ask regarding the case studies, please see contact details below:

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- Ark Housing – mark.hall@arkha.org.uk
- New Routes Home – newrouteshome@gmail.com
- British Red Cross – HCScotlandBDT@redcross.org.uk

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