Delayed discharges

A symptom of the challenges facing health and social care

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Contents

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Audit team

The core audit team consisted of: Kathrine Sibbald, Adam Bullough, Naomi Ness, Nathalie Cornish and Lindsay Stother, under the direction of Carol Calder.

Key facts

17,915	Number of times people experienced a delayed discharge in 2024/25
720,119 days	The number of hospital bed days lost due to delayed discharges in 2024/25
1 in 9	Proportion of beds occupied due to delayed discharges in 2024/25
3.2%	Delayed discharges as a proportion of adult inpatient discharges in 2024/25
66% **34%**	The percentage of all delayed discharge bed days occupied in 2024/25 by people aged: 75 years and above 18 to 74 years

Key messages

1 A delayed discharge is when someone remains in hospital despite being medically ready to leave. During the month of October 2024, Public Health Scotland reported the highest number (2,030) of people experiencing a delayed discharge at the monthly census point. The number of delayed patients has decreased slightly since the peak levels in October 2024, but numbers remain well above pre-pandemic levels and are rising again. In 2024/25, people delayed from being discharged spent 720,119 clinically unnecessary days in hospital. While the full costs to the health and social care system are likely to be much higher, we estimate the cost of hospital days alone to be over £440 million a year.

2 Despite only around three per cent of all people discharged from hospital experiencing a delay, each delay has a detrimental effect on the individual's physical and mental wellbeing. This includes increased risk of infections, reduced mobility and independence and can result in higher social care needs upon discharge. Delays also impact the flow of patients through hospitals, reducing staffing availability and capacity for other patients, and in 2024/25 resulted in 11.7 per cent of hospital beds being unnecessarily occupied. This means that the system cannot function as intended, and it will be challenging to meet the projected increase in demand if delayed discharges are not reduced.

3 While the reasons behind delayed discharges are complex and vary significantly by area, hospital and each patient, it is a symptom of much wider challenges across the health and social care system. NHS Scotland, councils, integration authorities,

as well as the third sector and independent providers, all face significant financial challenges. Demand for health and social care services continues to rise. Capacity across the system is constrained by workforce recruitment and retention problems, which are particularly acute for rural and remote areas. The priorities, strategies, cultures and systems of the many national and local bodies involved vary, creating complicated governance, planning and delivery arrangements, which can affect how efficiently patients can be discharged once they are well enough.

4 The Scottish Government, integration authorities and their partners, the NHS boards and councils, have actively targeted delayed discharges as an issue. This has led to some improvements, but this varies across the country. The lack of a consistent approach to evaluating initiatives makes it very difficult to understand their impact. Better analysis and transparency are needed to understand both the costs and impacts of delayed discharges, what is providing better quality of outcomes for individuals and value for money for public spending.

5 Limited progress with addressing the wider challenges in the health and social care sector restricts further progress with reducing delays. Scotland's population health framework, the health and social care service renewal framework and the NHS operational improvement plan, offer an opportunity to make progress, with a common focus on prevention. But it's not clear how shared accountability and joint decision-making will be achieved, particularly given there is limited reflection of the critical role of social care, and of integration joint boards and health and social care partnerships in the arrangements.

Recommendations

Jointly, the Scottish Government, NHS Scotland, the Convention of Scottish Local Authorities (COSLA), Healthcare Improvement Scotland, integration authorities and their partner NHS boards and councils, should:

- Over the next 12 months, develop a consistent approach to evaluating and reporting on initiatives to improve delayed discharges, such as discharge without delay and the Lothian Partnership, and sharing best practice and areas for improvement. Evaluation should be reported annually and include assessing effectiveness, value for money, and whether the initiatives are improving the balance of care. This evaluation should be used to update current discharge planning guidance (paragraph 109).
- In the next six months, publish guidance to clarify and strengthen the role of integration joint boards and health and social care partnerships in the governance and delivery of the health and social care service renewal framework (paragraph 106).
- Over the next 12 months, provide guidance on, and better promote public awareness of the benefits of, establishing a power of attorney or a guardianship order (paragraph 84).
- Over the next 12 months, work together to develop and action an implementation plan to share learning and practice from digital solutions used for tackling delayed discharges, early intervention and prevention (paragraph 95).

Jointly, the Scottish Government and Public Health Scotland should:

- Produce a clear estimate of the total costs of delayed discharges and the savings being made through initiatives to reduce delayed discharges. This should be completed within the next 12 months, updated regularly and reported in the annual analysis of delayed discharge performance (paragraph 111).

The Scottish Government should:

- Assess the current measures for monitoring performance in reducing delays and establish a suite of key indicators. These should be agreed by working in consultation with NHS boards and integration authorities to ensure indicators are both evidence-based and relevant to local circumstances, while focused on improving hospital flow and clearly linked to improving outcomes. This should be completed within the next 12 months, regularly reviewed and reported in the annual analysis of delayed discharge performance (paragraph 114).

Jointly, integration authorities and their partner NHS boards and councils should:

- In the next six months, ensure they fully implement the Carers (Scotland) Act 2016 by understanding the point of the discharge planning process where this is failing to happen, intervening with support for local areas to improve their processes for carers to be involved in discharge planning from the point of admission (paragraph 71).

Introduction

Background

1. Most patients in Scotland's hospitals are discharged promptly. In December 2025, Public Health Scotland (PHS) reported that in 2024/25, 97 per cent of adult inpatients were discharged without delay. In three per cent of adult inpatient stays, or 17,915 inpatient stays, the patient experienced a delayed discharge, meaning they remained in hospital beyond the point they were medically ready to leave.[1] This could be, for example, due to a lack of available home care services, delays in securing a care home place, or waiting for adaptations to be made to their home.

2. Delayed discharge has significant implications for an individual's wellbeing. Staying in a hospital longer than necessary can lead to deconditioning (deterioration of a person's physical/mental health), loss of independence, and a higher risk of infections.

3. Delayed discharges pose significant challenges in the health and social care systems. Prolonged hospital stays add to the cost of providing health and social care services, they contribute to bed shortages and make it harder for new people to be admitted, including those needing emergency care. Staff resources are stretched as hospitals must care for patients who no longer require acute medical care. It can also mean an increased need for social care support on discharge due to the detrimental impact on the person's wellbeing.

Health and social care were integrated to improve care and support for people and address issues such as delayed discharges

4. The health and social care sector involves a wide array of national and local bodies from the public, third and the independent sectors. Priorities, strategies and cultures vary making coordinating and leading change across the sector complex.

5. In 2016, the Scottish Government legislated under the Public Bodies (Joint Working) (Scotland) Act 2014 to bring together health and social care into an integrated system to improve care and support for people who use services, their carers, and their families. This included addressing whole-system issues such as delayed discharges. This led to 31 integration authorities (IAs) being created in Scotland that are responsible for strategic planning of designing, delivering, and coordinating health and social care services and have a key role in reducing delays in discharge.

6. The size of IAs varies depending on council boundaries. Most NHS boards have two or more IAs within their boundary, but the number ranges from one to six IAs in others.

7. IAs are currently structured in two ways, either through an integration joint board (IJB) or using a lead agency model. You can find more information about integration arrangements in our short guide. All areas except Highland elected to adopt the IJB model. Clackmannanshire and Stirling decided to form a single IA to service the needs of both areas. In December 2024, members of the Highland Council and NHS Highland Joint Monitoring Committee agreed to move from the lead agency model of integration to the IJB model.

About this audit

8. This performance audit aims to assess how well the challenge of reducing hospital delayed discharges is being addressed in Scotland. The audit provides oversight of the factors that contribute to delays and analyses the impact of initiatives put in place to address them.

9. Our findings and recommendations in this report are based on evidence gathered through document review, data analysis and interviews. To better understand how local pressures and challenges are being addressed, our work focused on three IAs – Dundee City, East Ayrshire and Highland, engaging with IA officers and those within the NHS board and council partner bodies. In the report, we include examples from these sample areas. These are not necessarily examples of best practice or the only approaches being taken across the country. We also engaged with Scottish Government policy leads, chief officers of integration authorities, chairs of IJBs and a range of national organisations across the public and third sector.

10. The scope of our audit focused on the reasons for, and implications of, delayed discharges and the actions taken to reduce them. The audit has looked at the impact of delayed discharges on people through secondary evidence and engagement with external stakeholders.

11. This report is accompanied by an online interactive delayed discharges tool that allows users to explore the national and local performance of IAs. The tool also includes local and national contextual data from the 2022 census that illustrates the increasing population pressures nationally and the significant variation across Scotland.

1. Delayed discharges – what's the problem

Delayed discharges have a detrimental impact on the people affected and on the wider health system. They are a symptom of the many demographic, population health, workforce, governance and financial challenges faced by the health and social care sector.

The number of people delayed in hospital has decreased slightly from the peak levels in October 2024, but numbers remain well above pre-pandemic levels and are rising again

12. Public Health Scotland (PHS) collects, analyses and publishes data on delayed discharges. In the financial year ending 31 March 2025, PHS reported that people who were delayed from being discharged spent 720,119 days in hospital, marking the highest annual figure reported since current recording guidelines were introduced in July 2016.[2] This was an increase of almost 33 per cent from the financial year prior to the Covid-19 pandemic, where the total days delayed patients spent in hospital was 542,204. The number of people delayed from being discharged at the monthly census point peaked in October 2024 at 2,030 (Exhibit 1, page 11).

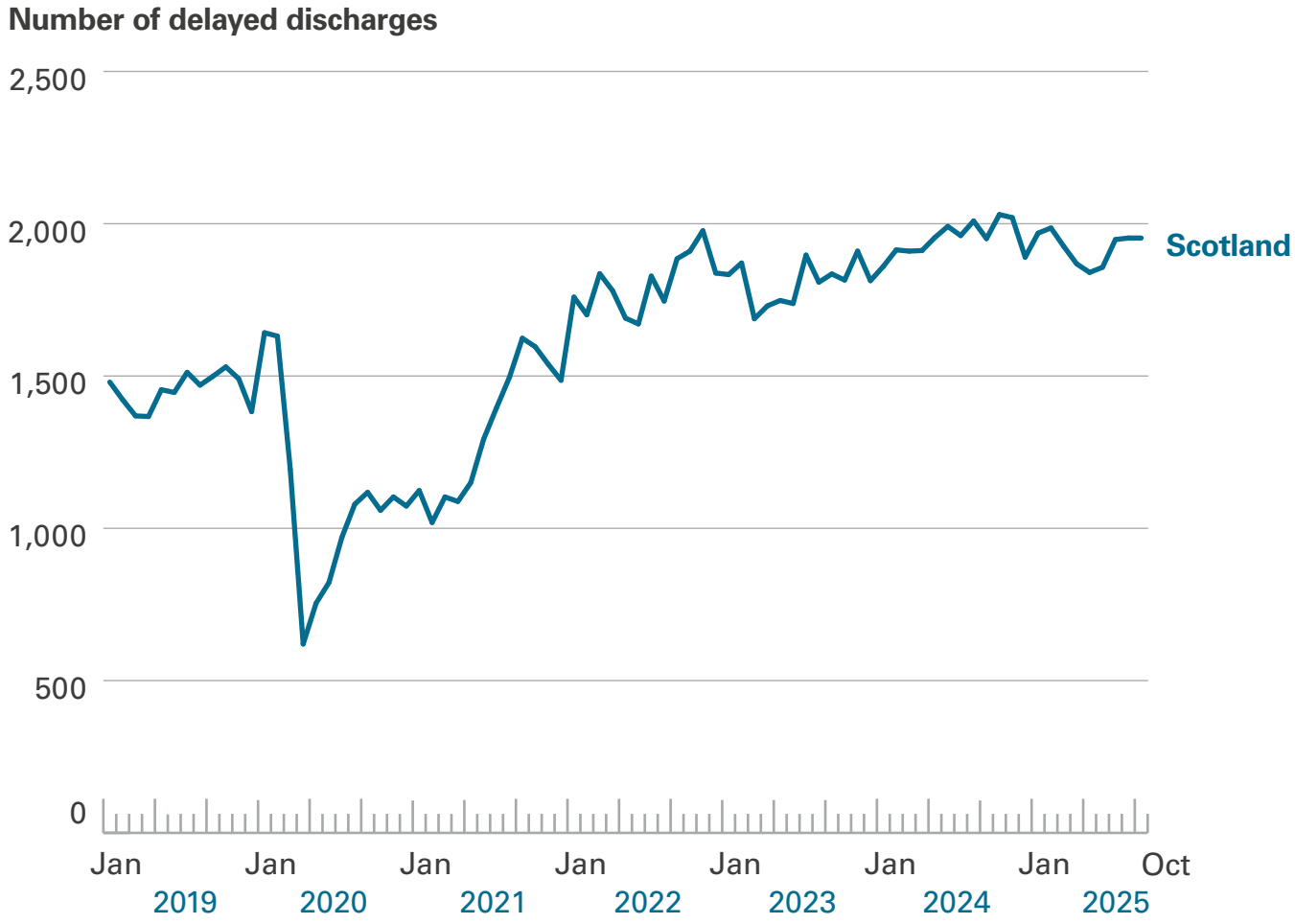
13. Of the 720,119 bed days occupied by people delayed in their discharge in 2024/25, 66 per cent were occupied by people aged 75 and over.

14. Following this peak in October 2024, the number of people experiencing delays each month started to slowly decrease, to 1,840 in May 2025. However, delays at the monthly census point have risen again. The most recent data, to October 2025, shows a 3.3 per cent reduction from October 2024, with 1,962 people delayed from being discharged.[3]

Exhibit 1.

Total number of delayed discharges in Scotland at the monthly census point, between January 2019 and October 2025

The total number of delayed discharges in Scotland at the monthly census point have risen substantially since 2020 and short-term reductions in the numbers have not been sustained.



Note: The large drop in early 2020 reflects the impact of special measures undertaken due to Covid-19.

Source: Delayed discharges in NHS Scotland monthly, figures for October 2025, Public Health Scotland, December 2025

15. At a local level, there is significant variation in the trends of the numbers of delayed discharges between IAs. This reflects the varying contexts, needs and challenges of different areas. Between October 2024 and October 2025, delays at the monthly census point have ranged between 3.9 per 100,000 population in Renfrewshire (September 2025) and 152.5 per 100,000 population in Eilean Siar (March 2025).[4] Between October 2024 and October 2025, 17 IAs have reduced their level of delayed discharges, while in 14 IAs, delayed discharges have increased. The Appendix contains a table of all IAs' performance (number and rate of delays at the monthly census point) between October 2024 and October 2025.

Delayed discharges have a detrimental impact on the people affected

Staying in a hospital longer than necessary can lead to deconditioning, loss of independence and a higher risk of infections

16. Delays in discharge negatively impact patients, leading to **deconditioning**, higher infection risks, and reduced mobility, especially in older or frail individuals. Frailty is common among those over 65 and affects over half of adults in hospitals or care homes.[5] People with dementia and/or frailty often have longer hospital stays, worsening their symptoms and physical health. Just 24 hours in bed can reduce muscle power by two to five per cent, and up to 20 per cent in seven days, increasing fall risks and care needs.[6] Lack of physical activity can lead to dependency and demotivation, while bright, noisy wards may cause stress and confusion.

Deconditioning is the gradual decline in physical, psychological, and functional capacity due to reduced activity or prolonged immobility.

Longer delays, typically faced by adults with incapacity, have profound impacts on the individuals and their families

17. Adults with incapacity are people aged 16 or over who lack capacity to make some or all decisions due to mental illness, learning disability, dementia or a related condition, or an inability to communicate. Adults with incapacity face risks of their human rights not being met. Their right to independent living can be affected by long stays, leading to a disconnection from family, friends and community, institutionalisation and a deterioration of mental as well as physical health.

18. Adults with incapacity generally have a longer length of delay in hospital. Patients delayed in their discharge for standard, non-complex reasons in 2024/25 experienced an average delay of ten days.[7] In 2024/25, there have been between 146 and 180 patients at each monthly census point who have experienced a delay of over 12 weeks because of incapacity.[8] Of these, between 35 and 65 people each month have been delayed more than six months. Delays in securing legal mechanisms like **power of attorney** and **guardianship orders** are a significant barrier to timely discharge.

19. Addressing these delays requires close collaboration between health, legal, and social care systems to ensure timely and appropriate discharge planning. Patients with a long length of stay in hospital (considered three weeks or more) tend to be in poorer health and may require more support upon discharge. They also face a higher risk of re-admission.

20. Complex and lengthy legal processes can conflict with a person-centred, human rights-based approach to care that seeks to support adults with incapacity and their carers with shared decision-making. Waiting for guardianship orders to be processed and approved by the court before more suitable accommodation and/or care arrangements are found can lead to lengthy delays. According to a 2024 Mental Welfare Commission report, the number of existing guardianship orders has more than doubled in the last ten years.[9]

Power of attorney is a written document giving someone else authority to take actions or make decisions on your behalf. The power of attorney details the names of the people, known as attorneys, who you want to help you and lists the individual powers that you want them to have.

Guardianship order is a court appointment which authorises a person to act and make decisions on behalf of an adult with incapacity. Anyone with an interest can make an application for a guardianship order.

21. In February 2025, NHS Greater Glasgow and Clyde reported that they had over 100 people delayed due to a lack of a power of attorney, roughly equivalent to four acute inpatient wards.[10] It highlighted that around a third of patients were delayed from being discharged from hospital because they did not have a power of attorney in place.

Delayed discharges increase pressures on the wider health system

22. People who are delayed in their discharge occupied approximately one in nine hospital beds in Scotland in 2024/25, considerably reducing the beds available for incoming emergency and planned patients.[11] This adds to existing pressures in the health system, making it more difficult to admit patients, contributing to overcrowding in emergency and assessment units and increasing planned care waiting lists.

23. A lack of available beds also exacerbates pressure across ambulance services and increases stress on the workforce. These impacts have been highlighted in our NHS in Scotland 2023 report and again more recently in our NHS in Scotland 2024 report.

24. It will be challenging for health boards to increase acute hospital capacity to meet the projected increase in demand if IAs and their partners are not able to reduce delayed discharges. This will place even more pressure on limited hospital beds and may pose risks to patient safety if there is not the capacity to meet patient needs.

The cost of delayed discharges is unknown, but in 2024/25, the total estimated cost of the 720,119 bed days occupied by delayed discharges alone was over £440 million

25. There has been no published information on the costs of delayed discharges since 2019/20. PHS advises this is due to challenges in receiving patient level costs from NHS boards since the Covid-19 pandemic. In the absence of up-to-date costs relating to delayed discharges, we have used the NHS cost book to calculate the approximate cost of providing the type of hospital care a person experiencing delayed discharge may receive.

26. Based on 2023/24 costs, the average daily net cost of a hospital bed in Scotland where a patient receives nursing, allied health professional (AHP) and other direct patient care (excluding medical, pharmacy, laboratory and operating theatre-related care) is estimated at £618.[12] This compares with £144.72 per day for a publicly funded care home placement with nursing, and £126 per day for a publicly funded residential care home placement.[13]

27. Assuming a daily cost of £618 for a hospital bed, in 2024/25 the total estimated cost of the 720,119 bed days occupied by delayed discharges alone was over £440 million. This is a minimum estimated cost as it does not include wider costs across the health and social care system resulting

from delayed discharges. For example, opportunity costs associated with the reduced capacity for planned care, and the potential costs of additional care required post-discharge due to deconditioning experienced during an extended hospital stay.

28. Reducing delayed discharges would not directly generate a cash saving as it would transfer the costs to other parts of health and social care, and the hospital beds would be occupied by others in need of care. However, ensuring that a person is cared for in the most appropriate place for them may be more cost effective. The Scottish Government needs to be able to understand the true costs of patients' delayed discharge from hospital and the savings and individual benefits being made through initiatives to reduce delayed discharges (paragraph 111).

Delayed discharges occur for many different reasons

Most delayed discharges happen as a result of trying to ensure that appropriate care arrangements are in place

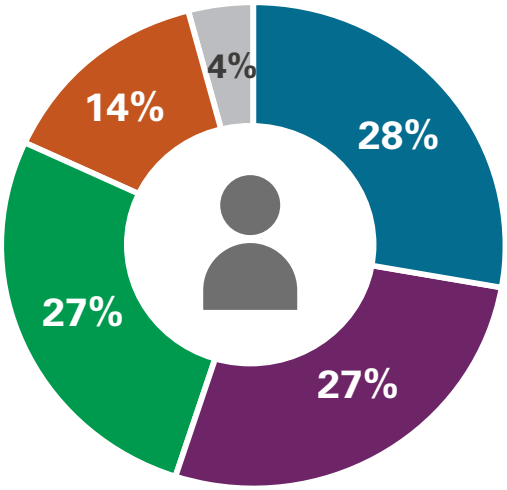
29. Once someone is medically ready to be discharged from hospital, there are a range of reasons why their discharge might be delayed and they are kept in hospital.

30. Exhibit 2 (page 15) shows the proportion of delayed discharges by reason for delay in 2024/25, of the average 1,967 people delayed in their discharge recorded at each monthly census in 2024/25.

Exhibit 2.

Percentage of delayed discharge reasons, average number across monthly censuses between April 2024 and March 2025

28%	**Awaiting place availability:** for example, waiting for a care home place.
27%	**Complex delays:** people delayed due to awaiting place availability in a high-level needs specialist facility, and where an interim option is not appropriate or where an adult may lack capacity.
27%	**Awaiting completion of care arrangements:** for example, people waiting on a care package (eg, home care, equipment support services).
14%	**Awaiting community care assessment:** for example, people waiting for a formal evaluation of their care needs by community-based professionals (eg, social workers, occupational therapists, or other adult social care staff).
4%	**Other reasons:** includes patient and family-related delays, awaiting funding and transport.



Source: Delayed Discharges in NHS Scotland, Annual summary of occupied bed days and census figures: Data to March 2025, Public Health Scotland, June 2025

Delayed discharges are a symptom of the many challenges faced by the health and social care sector

31. NHS Scotland, councils, integration authorities, as well as the third sector and independent providers, all face significant challenges (Exhibit 3, page 16).

Exhibit 3.

Delayed discharges are a symptom of the many challenges faced by the health and social care sector

Challenge area	Key issues
The financial challenges facing health and social care services are critical	The NHS in Scotland is experiencing immediate financial pressures, as noted in the NHS in Scotland 2025: Finance and performance report. Scotland's councils continue to face severe financial pressures, as highlighted in the Local government in Scotland: Financial bulletin 2023/24. In our Integration Joint Boards: Finance bulletin 2023/24, we reported that 24 Integration Joint Boards (IJBs) reported a financial deficit in 2023/24, with the projected funding gap for IJBs worsening to £457 million for 2024/25. IJBs are making difficult decisions about funding and providing services, often relying on dwindling financial reserves and non-recurring savings, which is not sustainable long-term.
Health and social care governance is complicated, and arrangements vary making partnership working and delivery complex	Different priorities, strategies, and cultures among the national and local bodies involved in community health and social care, create a web of shared responsibility, complicating decision-making, governance, planning, and operational activities as we highlighted in the Integration Joint Boards: Finance and performance 2024 report. The NHS in Scotland: Spotlight on governance highlighted some NHS boards have created strong relationships to support better planning and decision-making, but others struggle with limited control or influence over IJB decisions.
The demand for health and social care services continue to grow with the needs of an ageing population	Rising demand and budget pressures mean Integration Authorities face challenges in providing services that fully meet the care needs of their populations. Health inequalities are widening, with a focus on crisis medical treatment rather than preventative measures to maintain good health and wellbeing in the community. Pressure on hospital bed capacity is likely to grow, with unplanned acute inpatient hospital admissions in Scotland projected to increase by 11.8 per cent from 2024 to 2034.

Cont.

Challenge area	Key issues
Significant workforce recruitment and retention challenges impact on the capacity to deliver services	Workforce shortages, high vacancy rates and challenges with staff retention have resulted in gaps in social work, social care services, allied health professionals, nursing, and general practice. Recruitment and retention are particularly problematic in rural and remote areas. These challenges have been worsened by the impacts of Covid-19, EU withdrawal, increases in national insurance contributions and changes to UK-wide immigration policy.
A lack of suitable housing makes it harder to provide care, particularly in more remote and rural areas	There is a lack of planning for the future housing needs of an ageing population. Most housing stock is not built with people's longer-term care needs in mind. A shortage of suitable, affordable homes impacts key worker recruitment and retention. Delays in housing adaptations for people with learning disabilities and complex needs result in a lack of access to independent living options and prolonged stays in unsuitable accommodation or hospital. Limited housing options for staff make increasing or maintaining service capacity difficult in some areas.

Source: Audit Scotland

2. Delayed discharges – what's happening

There is significant activity to reduce delayed discharge, with examples of good practice, but a lack of evaluation means it is difficult to understand the overall impact.

The Scottish Government, integration authorities and their partners have actively targeted delayed discharges, but more needs to be done to effectively measure the impact and value of approaches

32. Many of the national and local initiatives to reduce delayed discharges are still at an early stage and are too recent to assess impact and effectiveness. Some initiatives lack outcome measures or published outcomes, making it difficult to make judgements of the overall impact in reducing delays and whether they are delivering value for money.

Reducing delayed discharges is a priority for the Scottish Government, with a focus on preventative actions

33. The Scottish Government's 2024/25 Programme for Government[14] reiterated its commitment to reducing delayed discharges and the variation in practice across Scotland. It outlined activities such as ensuring that partners work together to support effective discharge and reducing hospital admissions by providing the right care in the right setting.

34. The most recent Programme for Government, published in May 2025, and the NHS Scotland operational improvement plan,[15] published in March 2025, emphasise a focus on prevention, through ensuring more people can be cared for at home and reducing pressures in hospitals. This will be achieved by expanding the number of **Hospital at Home (H@H)** beds to at least 2,000 by December 2026. It also commits to ensuring frail patients with complex needs receive the wrap-around care they need to return home or into a care setting as soon as possible, improving hospital discharges.[16]

The Scottish Government and COSLA have a structured approach to tackling delayed discharges through regular monitoring, collaboration and targeted support, but this lacks transparency

35. The Scottish Government and COSLA place a significant emphasis on performance management and monitor the numbers of delayed discharges nationally and in each IA, engaging with local health systems to understand performance fluctuations.

Hospital at Home (H@H) provides urgent short-term hospital level care at home. This may range from one day to several weeks which would otherwise be spent in hospital.

36. The Scottish Government and COSLA gain assurance over the performance of IAs through review of weekly management information on the number of delays, alongside discussions with HSCP leaders to understand the reasons behind performance, challenges and mitigations being put in place. This intelligence is shared with other leaders within the health and social care system, and performance is monitored by the First Minister and the cabinet.

37. The Collaborative Response and Assurance Group (CRAG) is a key part of the approach. It is co-chaired by the Cabinet Secretary for health and social care and COSLA health and social care spokesperson. It brings together leaders from across health and social care to coordinate responses and ensure the delivery of effective services. It focuses on areas of concern, such as delayed discharges from hospitals, by holding regular meetings to monitor performance and implement improvement strategies.

38. The Scottish Government and COSLA intended CRAG meetings to provide local oversight and consider the reasons behind high levels of delayed discharges and why the number of delays were not improving. This was difficult for some local areas for often multiple and complex reasons. Three working groups were established:

- Working Group 1: A targeted performance and support work group – Rapid Peer Review and Support Team (RPRST) has engaged directly with the local systems and worked locally to improve performance (paragraph 48).
- Working Group 2: Focuses on delays related to learning disabilities and mental health, including adults with incapacity. The group allows for more intensive work in these areas.
- Working Group 3: Designed to look at national issues. Chaired by COSLA. It identified local case studies to highlight good practice.

39. There have been tensions with CRAG's directional approach and how data is presented. The approach to meetings has developed over time, and general feedback is that meetings have evolved into a more collaborative space that offers a forum for sharing best practices. But there is a lack of transparency outside of the group. The Scottish Government and COSLA intend to review the remit and focus of CRAG to ensure it aligns with NHS board operational planning processes and the remit of the National Care Service (NCS) Interim Advisory Board.

40. While CRAG has established a structured approach to tackling delayed discharges through regular collaboration and targeted support, the persistence of high delayed discharge figures and significant variation in certain regions indicates that further efforts, with better analysis and evaluation of what is providing better quality outcomes for individuals, are necessary to achieve significant and consistent reductions across Scotland.

In June 2025, the Scottish Government allocated additional funding of £92 million to NHS boards to improve unscheduled care services and to support the delivery of the NHS Scotland operational improvement plan

41. Reducing delayed discharges is a national priority for the Scottish Government, COSLA and IAs. In February 2025, the Scottish Government invited all NHS boards to bid for additional funding to improve unscheduled care services, supporting the delivery of the NHS Scotland operational improvement plan.[17] The Scottish Government was unable to approve the entirety of each NHS board's plans because these exceeded the total additional funding available. Ultimately, the additional urgent and unscheduled care funding for 2025/26 were made up of:

- Hospital at Home funding – £21.3 million
- improving flow, discharge without delay, and frailty services – £39.7 million
- core unscheduled care funding – £29.8 million
- mental health/adults with incapacity/learning disabilities – £824,000.

42. The Scottish Government has set out that it expects NHS boards to consider how they use the additional funding to redesign services and realign existing budgets to fully deliver on their proposals. The allocation of this additional funding is conditional on the delivery of these outcomes. The Scottish Government has set out that it will monitor progress and identify any slippages. It is the intention for the funding for future years to be made recurrent based on activity, actual spend, and evidence of delivery of outcomes required. As not all plans or initiatives have been fully funded, NHS boards will need to consider how existing budgets can be used to support their proposals.

43. The Scottish Government has a long-standing commitment to shift the balance of care from secondary, acute health services to primary and community services. Our 2016 report on Changing models of health and social care noted that the continued focus on challenging secondary care targets and short-term funding was making shifting the balance of care difficult. These issues remain, and the Scottish Government has recognised the continued need to make a long-term shift in the balance of care in its health and social care service renewal framework.[18] It aims to do this by focusing new resources on building capacity and service improvement in primary and community care, leading to community services receiving an increasing share of investment over time.

44. Within IAs, there are opportunities to maximise the impact of financial resources by organising services around people's needs, rather than traditional service/professional boundaries. However, current financial challenges make this difficult and it requires collaborative leadership.

The National Care Service (NCS) Advisory Board has a remit to provide advice and suggest where improvements can be made to social care, social work and community health services. Hence it has a key role in supporting the sector to reduce delayed discharges

45. The NCS interim advisory board was set up in May 2025 to provide advice and suggest where improvements can be made to social care, social work and community health services. The aim of the interim board is to help ensure services are consistent, fair and high-quality across Scotland hence it has a key role in supporting the sector to reduce delayed discharges. The board includes people with personal experience of accessing and delivering social care, social work and community health services. It is important that the NCS advisory board is aligned with the existing groups and adds value by advising on embedding lived experience into system design, strengthening collaborative governance, developing approaches for wider participation and providing agile, evidence informed advice, rather than adding a further layer of governance, which could result in further complexity, lack of transparency, and unclear accountabilities.

The Health and Social Care Delayed Discharge and Hospital Occupancy Action Plan has encouraged local areas to focus on adopting best practice, with 11 boards embedding discharge without delay

46. The Scottish Government's Health and Social Care Delayed Discharge and Hospital Occupancy Action Plan (the Plan) was introduced in March 2023. It builds on the principles of its best practice discussion paper, transforming urgent and unscheduled care – optimising flow – discharge without delay, published in August 2021, and aimed to promote known good practice in terms of discharge planning and whole-system working (Exhibit 4, page 22).

47. IAs are required to complete annual self-assessments against the Plan and submit these to the Scottish Government. IAs are now on their third iteration of self-assessment. Some IAs have reported action plans against these self-assessments, but the Scottish Government has not finalised an overall summary of these self-assessments or detailed how IAs are progressing against the Plan, which makes it difficult to evidence whether the self-assessments are driving improvement.

Exhibit 4.

Health and Social Care Delayed Discharge and Hospital Occupancy Action Plan delivery actions

The Plan focuses on three delivery actions:

1. Good practice

Has focused on 'getting the basics right' by using the Discharge without Delay (DwD) programme, see Case study 3 (page 31). The DwD collaborative has developed guiding principles for boards to follow, and there are now 11 boards signed up that are at varying stages of embedding the DwD programme.

2. Data Management

A Whole System Pressures Dashboard has been developed through a collaboration between NHS National Services Scotland, Public Health Scotland and the Scottish Government. It provides a weekly summary of current pressures across the health and care system, with the aim of supporting strategic decision making. The data includes weekly discharge data, summary counts of people delayed by Health and Social Care Partnership, split by delay reasons. It also includes other data related to planned care, unscheduled care, the Scottish Ambulance Service (SAS), and other parts of the system. The usage of the dashboard can be tracked, and over 800 users have access to the dashboard. What is not clear is how individual IAs are using this data, and it is difficult to assess, as they all have different processes for analysing performance.

3. Workforce

Has looked at addressing labour shortages in social care through recruitment campaigns such as 'There's More to Care than Caring' and 'You Can Make a Difference'. But challenges remain with the workforce, and many IAs and independent care providers still face recruitment challenges across the health and social care sector in Scotland, see Exhibit 3.

Source: Audit Scotland

The Rapid Peer Response and Support Team has provided targeted support to IAs struggling with persistent delayed discharge pressures, and has been positively received, but lacks evaluation to understand the overall impact

48. The Rapid Peer Response and Support Team (RPRST), initiated by the Scottish Government, has provided tailored support to NHS boards and IAs that have faced challenges in reducing delayed discharges. They collaborate with IAs to identify issues and share best practices to improve performance in reducing delayed discharges.

49. The RPRST has worked closely with a variety of HSCPs to scope out bespoke packages of support. It focuses on problem identification and solving, encouraging peer support, and avoiding duplication and unnecessary bureaucracy. Some examples include:

- The Aberdeenshire HSCP worked with the RPRST to map patient pathways following discharge from hospital. Following the mapping exercise, the RPRST has worked with the Aberdeenshire HSCP to develop a Standard Operating Procedure (SOP) for facilitating the discharge of patients from Aberdeen Royal Infirmary to home or via community hospitals in Aberdeenshire to home or a homely setting. The Aberdeenshire HSCP is currently working with the RPRST on implementation of the SOP.
- With South Ayrshire HSCP, the RPRST helped scope Local Support Intelligence Team support from Public Health Scotland, which has enabled South Ayrshire to access data on the most frequent A&E attenders and updated trend analysis on single- and double-handed care.

50. The RPRST shares local intelligence and learning with CRAG and escalates any barriers or issues that cannot be resolved by the local area and RPRST. It maintains a network of peers to provide peer support. There has been positive feedback from boards that have been involved with the team, but there has not been any evaluation to assess the success of these initiatives and the direct impact they have had on improving performance in reducing delayed discharges.

Hospital at home is a nationally supported model that can prevent hospital admissions, but there is no analysis of its cost-effectiveness in relation to other models of community or home-based care

51. The Hospital at Home (H@H) programme has been implemented as a strategic response to alleviate delayed discharges by providing acute-level care in patients' homes. This initiative aims to reduce hospital stays, free up bed capacity, and enhance patient outcomes.

52. H@H has prevented an estimated 15,811 hospital admissions from April 2024 to March 2025, representing a ten per cent increase in the number of patients managed by H@H between April 2023 and March 2024.[19]

53. The 2025/26 Scottish Budget included a £100 million fund to support various reform and improvement measures, including reducing delayed discharges and expanding the capacity of H@H.[20] Some of this £100 million has already been earmarked for other purposes, such as a new cardiovascular service in general practice. In June 2025, the Scottish Government informed NHS boards of the funding arrangements for H@H, allocating £21.3 million for 2025/26, and confirmed the funding for future years will be made recurrent based on activity and actual spend incurred and evidence of delivery of outcomes required.

54. Health boards have highlighted that the requirement for H@H to be a secondary care consultant-led service can make it unaffordable. There is also a risk that finite resources are taken away from other areas, putting an additional burden on carers. While there is some evidence that H@H can be more cost-effective than hospital-based care, the Scottish Government or HIS have not completed a full assessment to analyse the cost-effectiveness of H@H in relation to other models of community or home-based care.

55. The Scottish Government has commissioned PHS to develop consistent national data on H@H activity. PHS plan to publish statistics quarterly from spring 2026 alongside updates by HIS on H@H improvement work. HIS and PHS should consider including metrics on the costs of H@H services, to allow assessments on the cost-effectiveness, relative to other models of care.

Flow Navigations Centres, Integrated Clinical Hubs and Pathways Hubs are virtual assessment hubs that help direct patients more efficiently and effectively

Flow Navigation Centres (FNCs)

56. FNCs are part of the Scottish Government's national initiative to improve access to urgent and unscheduled care by ensuring patients receive the right care, in the right place. They offer an opportunity for professional-to-professional advice with direct referrals from primary care, NHS24 and SAS with an aim to improve coordination of patient flow. This can contribute to reducing the number of people requiring hospital care by identifying alternatives to hospital admission, such as community-based care, specialist outpatient services, home treatment options and hospital at home services. Examples of the use of FNCs:

- NHS Lothian – With funding from the Scottish Government, NHS Lothian enhanced its flow navigation service by directing provision to consultant-led flow centres. The service has 11 consultants from acute medical and emergency medicine, offering a Monday to Friday 9am-6pm referral service. The new model aims to minimise the need for transfers to hospital, identify unmet need within the system and protect any one part of the system from becoming overburdened. Funding constraints means they are not currently able to operate a 24-hours-a-day, seven-day-a-week service.
- NHS Greater Glasgow and Clyde – Operate an enhanced FNC+ model, bringing together a multidisciplinary team to provide assessments and navigate patients to access alternatives to hospital admission when appropriate. Central to this development is the creation of a virtual hospital, which will provide 1,000 'virtual beds' across NHSGGC. Patients suitable for this model of care will be supported at home using remote monitoring technology and clinician-led interventions, allowing hospital-level care to be delivered without the need for a hospital stay.

57. FNC models and levels of expertise vary across Scotland, and it can be difficult to replicate for smaller boards who may have less resource to staff FNCs as well as access and capacity in the community. There is also no unified data set collected by PHS, which makes it difficult to compare activities and outcomes.

Integrated Clinical Hubs and Pathways Hubs

58. Scottish Ambulance Service (SAS) Integrated Clinical Hubs allow SAS to remotely assess and consult with patients avoiding unnecessary ambulance dispatch and hospital admissions and readmissions. The Pathways Hub is a single point of contact for SAS clinicians to access a range of proactive and preventative pathways.

59. The Integrated Clinical Hub has a remote multidisciplinary team of clinical advisers, advanced practitioners and GPs who engage with patients that would benefit from clinical assessment and review. The Pathways Hub provides pathways for those not requiring urgent or emergency care into preventative services such as falls prevention, alcohol and drug services, Distress Brief Intervention or social services, or refers patients to third sector providers that can best suit their specific needs.

60. Through the introduction of Integrated Clinical Hubs and Pathways Hubs, SAS manages around 50 per cent of emergency calls outwith acute emergency hospital settings. Patients can be supported at the point of call or by SAS clinicians on scene, reducing the need for hospital conveyance and potential admission. In June 2025, SAS highlighted that over 175,000 patients have been supported through the Hub, with more than 55,000 ambulance journeys being avoided.[21]

There is a focus on early identification, assessment, and management of frailty

61. Early identification and management of frailty through the provision of community frailty services is important to allow people to live as independently as possible, avoid unnecessary hospital admissions, readmissions, and reduce length of stay, if hospital admission is required.

62. Having a clinical focus on frailty at the 'front door' (the part of the hospital where patients initially present when unwell, such as an emergency department) and early comprehensive geriatric assessments can ensure that patients are supported by the most appropriate services.

63. The Scottish Government has set a target for every emergency department in Scotland to have direct access to specialised frailty teams by summer 2025, to support early identification, assessment and management of frailty at the hospital front door.[22] HIS has developed ageing and frailty standards and set foundations for front door frailty, which sits alongside its foundations for community frailty services and key steps to setting up a front door frailty service to help organisations implement the ageing frailty standards.

Getting it Right for Everyone principles have been developed to promote effective discharge planning and help prevent delayed discharges

64. Getting it right for everyone, or GIRFE, launched in May 2025, is a Scottish Government multi-agency approach to care that focuses on working together around the person. It responds to frustrations people have with the current system, such as repeating their story multiple times, navigating complex information and attending multiple appointments with different professionals. The Scottish Government worked with nine pathfinder health and social care partnerships, professionals and individuals receiving and providing care between 2022 and 2024 to develop the GIRFE approach.

65. A GIRFE toolkit has been developed to help practitioners apply a more personalised and preventative approach to care. The core principles focus on person-centred discharge planning, multi-agency coordination and, taking a consistent and 'whole-life' approach to ensuring an individual's needs are considered and necessary support is in place before discharge.

Discharge planning and processes vary across the country with many improvement programmes and initiatives evident

66. When a person attends a hospital for clinical care, an initial assessment should be completed to determine if their care needs can be properly met in any setting other than a hospital. The assessment should establish the best place for the person to have their clinical healthcare needs met. Where appropriate, they should be discharged to a suitable community setting, home with no ongoing support, home with support, a care home or supported accommodation.

67. If a person is admitted to a hospital, the discharge planning process should start immediately, to ensure the right care is available in the community at the time of discharge. This discharge planning process should be carried out by the responsible consultant, informed by the multi-disciplinary team (MDT), in partnership with the patient, family or carer, with their views and wishes being considered.

68. The approach to discharge planning varies across the 31 IAs. Some areas have embedded good practice involving collaboration of MDT, while others face challenges due to workforce shortages, limited resources and varying levels of cooperation and joint working

Unpaid carers are often involved too late in the discharge process

69. With an ageing population, people living longer with multiple complex health conditions, and care being brought closer to home, caring is likely to be a feature of most people's lives in the future.[23]

70. The Carers (Scotland) Act 2016 was introduced to provide carers in Scotland with additional rights. Part 4, section 28 of the Act provides unpaid carers the right to be involved in planning for discharge when the cared for person is admitted to hospital. In 2019, Health and Social Care Scotland published a practical guide for health and social care practitioners involved in discharge planning from hospitals.[24]

71. Involving carers early in the discharge planning process leads to smoother discharge and reduced delays. Readmissions are less likely as carers are better equipped to provide ongoing support, and their involvement leads to better informed care assessments. Despite this, there is still a lack of communication with carers, leading to assumptions around what support is or is not needed, and carers being often involved too late during the discharge process.

72. IAs are having to make difficult decisions on how to allocate limited budgets, and as a result some services are increasingly having to tighten eligibility criteria, such as for packages of home care. This means that people may have to rely more on family support and unpaid care.

73. An example of effectively involving carers as part of the discharge planning process is the collaboration between East Ayrshire HSCP and East Ayrshire Carers Centre.

74. East Ayrshire Carers Centre supports carers of all ages and recognises the need to involve families and carers from admission. They currently have two hospital discharge carer link workers based in University Hospital Crosshouse and University Hospital Ayr, as well as linking in with East Ayrshire Community Hospital and Biggart Hospital, working closely with the discharge without delay teams. They advise and support unpaid carers through the hospital discharge process and help identify what support they may require to continue to provide care and support for their loved ones after discharge, giving a more accurate picture of the patient's needs and available support.

Care packages are commonly cancelled on admission; changing this can reduce delays to discharge but is challenging to do

75. When someone is admitted to hospital, any existing care at home package will likely be cancelled as not being required, during the period of inpatient stay and restarted, if required, on discharge. This can save on costs and resources but impacts the continuity of care.

76. Keeping care packages open can speed up discharge. For example, in East Ayrshire IA, they try to keep care packages open for up to four weeks; this allows the continuity of care to be maintained, and it is less likely that this becomes a reason for a delayed discharge, but because of financial constraints and increasing demand, this is becoming more difficult. However, when care packages are kept open while an individual is in hospital, if demand for care packages exceeds capacity, this could mean that someone could be awaiting services in the community, so there is a delicate balance that needs to be managed.

Some IAs have used financial reserves to address delayed discharges in the short term, but this is not a sustainable option

77. Using reserves to address challenges such as delayed discharges, for example, to pay for interim care placements or boosting social care capacity during peak times, can have a positive impact on performance, but this is not sustainable.

78. In our Financial bulletin on IJB finances 2023/24, we reported that IJB reserves decreased by 36 per cent in real terms (adjusting for inflation) between 2022/23 and 2023/24. Contingency reserves, which are not earmarked for a specific purpose, decreased by 49 per cent in real terms. Some IJBs have used reserves to improve performance in reducing delays (Case study 1).

Case study 1.
Focusing on finances and reserves for reducing delays

Falkirk IA has experienced an increasing number of delayed discharges and struggled to maintain short-term improvements in performance. In 2023, Falkirk sought to understand the reasons behind increases in delays. The findings highlighted a lot of care at home waits, so the Health and Social Care Partnership focused on targeting specific blockages within the care at home service, using reserves to invest in care services to bring down delays. This resulted in an improvement from 87 delays at the April 2024 census point to 65 delays at the October 2024 census point, but the increased focus and spending resulted in a budget overspend.

Falkirk quickly introduced control measures to reduce spending, and the number of delays increased. Part of the control measures were to have two people come out of a care home bed before one person could go in, and a limit on care at home hours. Analysis of care at home demand showed that the investment resulted in the lowest level of unmet demand in the community in Scotland, essentially meeting all care needs. However, as reserves were utilised and with control measures in place, delays again increased.

Source: Falkirk Integration Authority

Local whole-system and multidisciplinary approaches reflect the complexity of delayed discharges

79. Individual approaches may improve specific aspects of the discharge process locally and have a positive impact on the levels of delayed discharge. However, as set out in Part 1, delayed discharges are a symptom of wider challenges within the health and care system, involving many different factors, services and professions. To have a significant lasting impact on the level of delayed discharges requires shared accountability and a collaborative approach from all stakeholders, at all levels, which is built on evaluation and uses data to support decision-making.

80. There are some examples of **whole-system** and multidisciplinary team initiatives which have had a positive impact on delayed discharges. For example, the Lothian Partnership unscheduled care improvement programme is a local application of a whole-system approach. This aimed to enable transformation of models of care to ensure long-term sustainability and has resulted in reducing delays (Case study 2).

A whole-system approach looks at all aspects of how a system operates, the role of each part within the system, and how they are connected. This can help understand how things can be done differently to improve systems.

Case study 2.
Lothian Partnership – unscheduled care improvement programme

In autumn 2024, there was a wider concern about the level of pressure across the whole system in NHS Lothian, with high hospital occupancy levels, especially in acute hospitals, and accident and emergency delays were very high. This was caused by several factors, including delayed discharges. The Scottish Government approached NHS Lothian to explore options to improve unscheduled care (USC) performance.

The programme initially focused on the Royal Infirmary of Edinburgh and aimed to create a whole-system approach to enable the transformation of care models, ensuring long-term sustainability. The programme looked to move towards better partnership working, home-first approaches and a seven-day USC staffing model. This included discharging patients every day of the week and shifting care from acute to community services.

The programme goals included reducing attendances, admissions, bed occupancy and length of stay in hospital, with data being used to support accountability and decision-making. It provided several benefits in respect of patient flow through the hospital, and although there was no focus or specific targets on delayed discharges, at the end of the 2024/25 financial year, NHS Lothian reported a reduction in delayed discharges at the Royal Infirmary of Edinburgh by 17 per cent and Western General Hospital by 32 per cent. Staff morale has improved, along with collaborative leadership and a belief in a whole-system approach.

Source: NHS Lothian

81. Multidisciplinary team (MDT) collaboration brings together health services, social care, housing, and community providers to coordinate care, share information, and streamline patient transitions. When these partners work closely, they can identify and resolve barriers more quickly, ensure appropriate support is in place post-discharge, and improve outcomes for patients. Strong, sustained collaboration fosters a more integrated system, reducing delays and improving overall efficiency. The Discharge without Delay (DwD) programme is another example of a collaborative, multidisciplinary, whole-system approach (Case study 3).

Case study 3.
Discharge without Delay (DwD) programme

The DwD programme was built on principles developed in Tayside and is a whole-system initiative designed for frail older people currently accessing hospitals in Scotland. It integrates best practices, individual services, and care pathways into a model that prioritises delivering a comprehensive geriatric assessment of the patient promptly, ensuring that patients experience no negative consequences from their hospital stay, while facilitating a smoother transition from hospital to home.

The DwD programme has four key integrated workstreams:

- Planned Date of Discharge (PDD) and Integrated Discharge Hubs Workstream – A single point of referral for complex discharges, setting a realistic planned date of discharge, supported by a MDT approach.
- Discharge to Assess (D2A)/Home First Workstream – The completion of social care assessment post discharge. Enabling people to return home without delay, through services that offer responsive community-based home care support.
- Community Hospital and Step-Down Rehabilitation Units Workstream – Enhanced use of these facilities to care for frail individuals requiring rehabilitation and extended assessments.
- Acute Frailty Unit Workstream – Frailty units early in the admission process in acute hospitals provide early comprehensive geriatric assessments for frail older people.

The DwD collaborative meets fortnightly and now has over 50 members across 11 boards in Scotland. All boards in the DwD group have undertaken a needs assessment aligned to the guiding principles set out by the DwD collaborative that will support the development of a comprehensive action plan to guide service, workforce, and budget planning for the year ahead and inform the respective annual delivery plan 2025/26.

The DwD collaborative has agreed on four key targets to reduce delayed discharges and their impact (detailed in paragraph 115). There are early signs that the DwD programme is now having an impact in reducing delays across some boards that have implemented the new principles, but boards are at varying stages of implementing service changes, and the principles will take time to fully embed.

Source: Discharge without delay collaborative

Power of attorney and guardianship orders can be a lengthy, complicated process with long waits for legal aid

82. In December 2024, Health and Social Care Scotland funded the development of a power of attorney stakeholder toolkit and associated media campaign around a national power of attorney day to raise awareness of the importance of having a power of attorney in place.[25] As for many, especially those on lower incomes, having a power of attorney in place is not considered a priority. In more rural areas, this can be challenging, for example, in Highland, there are very few solicitors who accept legal aid due to capacity. According to the Scottish Legal Aid Board (SLAB), in 2024–25, adults with incapacity cases accounted for 47 per cent of all grants, up from just two per cent in 2005–06.[26]

83. There may be opportunities for IAs to target proactive support for patients who are most likely to require a power of attorney. For example, East Ayrshire HSCP has been supporting dementia patients to set up a power of attorney. Working with Alzheimer's Scotland, they are supporting individuals and their families to put in place a power of attorney during dementia post-diagnostic support, while they still have capacity. A range of teams across the HSCP are engaged in supporting power of attorney discussions at the earliest opportunity across the wider population. Work is under way to ensure there is a shared approach to identification, promotion, and provision of power of attorney, including market testing to explore improved access to quality assured legal partners.

84. Our stakeholder engagement has highlighted that better public awareness of power of attorney and guardianship orders is needed, and support for those on lower incomes may be useful to ensure families have them in place before they are admitted to hospital.

85. The Scottish Government is considering changes to the Adults with Incapacity (Scotland) Act 2000 to better protect people's rights and dignity, and the 2024/25 Programme for Government, published in September 2024, committed to bringing forward a Bill amending the Adults with Incapacity legislation. Between July and October 2024, the Scottish Government carried out a consultation on its proposals, publishing analysis from these consultations in January 2025.[27] The responses to the consultation will inform the development of that legislation and the accompanying guidance and revised codes of practice.

The third sector is a key partner in tackling delayed discharges, especially in community-based interventions and carer support

86. Many IAs rely on third sector organisations to deliver social care services, including care home and care at home services. They also rely on the third sector to deliver services that enable timely discharge, such as housing support, befriending, and palliative care.

87. For example, the British Red Cross (BRC) supports health and social care across the UK, providing services in hospitals, primary care, social care and in the community. Their services include home from hospital support, assisted discharge, reablement, patient transport and discharge to assess, enabling faster, safer discharges and reducing the likelihood of readmission:

- In East Ayrshire, the BRC is a key delivery partner offering assisted discharge, transports such as oxygen and stretcher transport, and non-regulated support services such as practical and emotional support to people for up to 12 weeks after discharge.
- In partnership with Ninewells Hospital and Dundee HSCP, the BRC has co-developed a D2A model. Assessments are done in the person's own home, and the Red Cross can provide wrap-around care and support during the assessment process for up to 21 days.

88. The Health and Social Care Alliance Scotland (the ALLIANCE) reported in April 2025,[28] that overall, there had been local examples of good practice with health and social care integration across IAs, but these are yet to be adapted and implemented at scale. The ALLIANCE further reported that effective partnership working and collaboration between the third and public sector are undermined by financial challenges, negative attitudes toward the third sector, and complex organisational processes.

89. As significant contributors in the delivery of community health and social care services, the third sector and, where appropriate, the independent sector, should be involved in developing approaches to whole-system change.

Digital solutions are playing an increasingly vital role in tackling delayed discharges

90. The use of artificial intelligence (AI) and digital technology is a powerful tool that can transform access to healthcare, improve efficiency and support long-term savings and better integration:

- Remote and virtual care with enhanced online accessibility reduces the need to travel and virtual assistants can provide health advice, triage symptoms, and guide patients to appropriate care 24/7.

- AI can help hospitals and health professionals allocate resources more efficiently and streamline administrative tasks. Our Tackling digital exclusion report gives examples of how digital options can improve access to services and help save money, such as the Near Me video consulting service.

91. An example of where digital technology has improved efficiency and supported better discharge planning by improving the interface between acute and community teams has been the launch by NHS Highland of a dynamic discharge app.

92. It follows the planned date of discharge principle of discharge without delay. The app links together multidisciplinary decision-making teams in both acute and community settings, improving communication to help ensure patients are put on the correct pathway as early in the process as possible. Upgrades to the app have included a clinical frailty scale, and a chat function to improve real-time communication to support the flow of patients through the hospital.

93. There is potential for AI and technology-enabled care (TEC) to support people to live more independently at home, including supporting the elderly and those living with dementia. Digital connections form part of East Ayrshire HSCP's longer-term strategic plan to align the Home First model of care to a Digital First principle promoting the use of TEC for independent living.[29] Recent innovations include the East Ayrshire smart hub which showcases different smart home technologies and is part of the Smart Supports initiative, using technology to provide services which can help people live independently within their homes and communities.

94. In our Community health and social care performance report, published in January 2026, we note that the Scottish Government has encouraged, through a number of workstreams, the growth of TEC. Although preventative initiatives to keep individuals in the community, such as the use of community alarms and telecare, have been used across IAs, the estimated number of people receiving community alarms and/or telecare is relatively static.

95. With the growing challenge of an ageing population, workforce shortages and rising costs, IAs should work together to share learning and best practice from these digital initiatives, as digital technology and digital innovations will be an important consideration in early intervention and prevention strategies.

3. Delayed discharges – what needs to happen

Scotland's Population Health Framework and the Health and Social Care Service Renewal Framework offer an opportunity for a common focus on prevention across health and social care. But it is not clear how the shared accountability and joint decision-making needed across all stakeholders will be achieved and how the underlying challenges in the social care sector will be addressed.

The lack of a consistent approach to evaluating initiatives makes it very difficult to understand their impact. More needs to be done to understand the true costs of delays, what actions and initiatives are providing better quality of outcomes for individuals, and which approaches represent value for money for public spending.

There is a long-term recognition of the need for extensive change in the health and social care sector to improve outcomes, including a focus on prevention, shifting the balance of funding and better collaborative working across sectors and organisations

96. In 2005, we published Moving on? An overview of delayed discharges in Scotland. In this report, we highlighted that solving the problem of delayed discharges needs action across all parts of the health and care system. In our Health and social care integration: Update on progress report, published in November 2018, we reported that significant changes are required in the way that health and care services are delivered, and highlighted:

- appropriate leadership capacity must be in place
- all partners need to be signed up to and engaged with the reforms

- partners also need to improve how they share learning
- change cannot happen without meaningful engagement with staff, communities and politicians.

97. At both a national and local level, all partners need to work together to be more honest and open about the changes that are needed to sustain health and care services in Scotland.

98. These messages were reiterated in our Integration Joint Boards: Finance and performance report, published in July 2024. It highlighted that we still have not seen significant evidence of the shift in the balance of care from hospitals to the community intended by the creation of IJBs. It also noted there is a lack of collaboration and systematic shared learning.

Scotland's population health framework and the health and social care service renewal framework provide high-level guidance for change, but more clarity is needed on how these ambitions will be achieved

99. In June 2025, the Scottish Government and COSLA launched Scotland's Population Health Framework 2025–2035 (PHF) and the Health and Social Care Service Renewal Framework (SRF). Both frameworks are a welcome development, recognising the need for a cross-sector approach to address the challenges of health and social care, with a focus on prevention at the core.

Scotland's population health framework provides a common vision, but it is not clear how shared accountability and joint decision-making will be achieved and there is limited reflection of the role of social care

100. The PHF sets out at a high level 'a ten-year approach to improving health and wellbeing in Scotland'. It focuses on population-level prevention by improving health outcomes and reducing inequalities across Scotland. It clearly recognises the need to engage across public, private and third sector bodies to have a meaningful impact on public health and wellbeing and address these inequalities.

101. Although delayed discharges are not a central theme, the scope of the framework, which includes a cross-sector approach focusing on prevention drivers of health and wellbeing, supports actions to indirectly address delayed discharges. Importantly, the role of social care, as a critical element in the infrastructure for public health, is not fully recognised. The framework largely reflects the issues from an NHS perspective. This imbalance risks the achievement of the aims of this framework, including improving outcomes such as reducing delayed discharges.

102. The framework is a positive step towards having common aims to achieve long-term improvement of outcomes, although it is not clear how the shared accountability and joint decision-making needed across all stakeholders will be achieved, and it remains to be seen whether the required cross-sector buy-in can be achieved.

The Health and Social Care Service Renewal Framework is an opportunity for progress to be made with health and social care reform but IJBs and social care need to be more central to the arrangements, and it is not clear how the framework approach will address the leadership, cultural, financial and governance barriers that integration has not managed to overcome over the past ten years

103. The SRF provides a high-level guide for change, to ensure the sustainability, efficiency, quality and accessibility of health and social care services in Scotland. It sets out a shift towards a community-orientated approach to health and social care which, in turn, will contribute to better integration of services to meet individuals' and families' needs.

104. The SRF aims to 'progress reform to ensure long-term financial sustainability, reduce health and care inequalities, further harness the benefits of digital technology, and improve health outcomes for people in Scotland'. The framework has the potential to reduce delayed discharges, improve workforce sustainability, and enhance patient outcomes, but only if it is implemented effectively and underpinned by genuine collaboration.

105. The SRF offers an opportunity to make the progress needed in the integration of health and social care. However, as with the PHF, there is limited reflection of social care or the role of IJBs. The Public Bodies (Joint Working) (Scotland) Act, 2014 (the Act) was intended to ensure that health and social care services were well integrated, that people receive the care they need at the right time and in the right setting, with a focus on community-based, preventative care. However, Scotland is yet to achieve this shift in the balance of care. The underlying challenges in the social care sector remain. It is not clear how the SRF approach will address the leadership, cultural, financial and governance barriers that integration has not managed to overcome over the past ten years.

106. Without IJBs and HSCPs being at the centre of the planning and decision-making about service renewal it is unlikely this framework will achieve the engagement and affect the change intended. In developing the plans to support this framework, more consideration is required of what this will mean for social care and social work services.

The NHS Scotland operational improvement plan looks to address delayed discharges through reducing the pressure in hospitals and by shifting the balance of care

107. The NHS Scotland operational improvement plan (2025–2026),[30] published in March 2025, is the Scottish Government's short-term plan that sets out actions that are intended to progress reform and enhance NHS delivery. The plan is a useful summary of current key initiatives and commitments but does not set out specific actions in any detail. It looks to address delayed discharges and the pressures on hospitals through

programmes such as H@H, approaches to manage frailty, including specialist frailty services and managing frailty at A&Es and access to GPs and primary health care.

108. As highlighted in relation to the PHF and SRF, these approaches cannot be achieved in isolation and need to be planned and progressed in partnership with the social care sector, primarily through the IAs and HSCPs. In isolation, the NHS is limited in how effectively it can achieve the aims set out in this plan.

The lack of a consistent approach to evaluating initiatives makes it very difficult to understand their impact and assess value for money

109. There has been significant work by the Scottish Government, integration authorities and their partners to reduce delays. Some regional areas are showing improved performance, but there has not been an overall assessment of the impact of these initiatives. Having a consistent approach to evaluating national initiatives for reducing delayed discharges and preventing hospital admissions would improve transparency of their effectiveness, if they are delivering value for money and if they are improving the balance of care which would help inform future resource allocation decisions.

The Scottish Government does not measure the total costs associated with delayed discharges

110. As of October 2021, PHS stopped reporting the underlying costs of beds associated with delayed discharges, which was due to metrics being out of date and likely an underestimate of the true cost.

111. At present, the Scottish Government does not measure the total costs associated with delayed discharges. The Scottish Government recognises this as a gap in its data, but given the priority and investment in reducing delays, the Scottish Government needs to be able to understand the true costs of delays and the savings made through initiatives to reduce delayed discharges. In a system under extreme financial pressure, it is essential that the Scottish Government can identify the cost of delayed discharges and take targeted action to reduce them, enabling more effective and productive use of resources.

The Scottish Government and COSLA do not have targets to monitor performance in reducing delays

112. The national mission to reduce delayed discharges was jointly agreed by the Scottish Government and COSLA, and between July 2024 and October 2024, the Scottish Government and COSLA assessed IAs performance against a national target of 34.6 delays per 100,000 population, based on a pre-pandemic rate, with each IA having to bring

down delays to a specific level to contribute to this national target. This was a time-bound target up to October 2024. By October 2024, the target was not met, with national performance at 44.8 delays per 100,000 population. A new target was not introduced.

113. The Scottish Government and COSLA now monitor IA performance based on the trajectories of the numbers of people delayed, outliers, and comparison with the Scottish average. At a national level, the delayed discharge rate has remained above 40 delays per 100,000 population, peaking at 44.8 in October 2024.

114. The Scottish Government, along with feedback from delivery partners and COSLA, advises that setting a single national target for delays may narrow focus and divert resources from community-based activities. While national targets can highlight key areas for improvement, they may not address the complexity of local issues. Measures should be set in consultation with partners to ensure they are evidence-based, sensitive to local circumstances, and linked to improved outcomes. Many local service providers prefer the indicators developed by the DwD collaborative, which considers the number of delays as one of several performance indicators.

115. Locally driven targets can help focus efforts to reduce delays where they will make the most impact. Analysis of local data on the processes and barriers faced in their local context has allowed some IAs to target investment and implement service changes that have resulted in reductions in delayed discharges. IAs involved in the DwD programme (Case study 3) have agreed four key targets to improve system flow, reduce delayed discharges and ensure actions put in place are achieving the intended impact:

- Reduce acute geriatric length of stay by more than 20 per cent compared to March 2024 levels, by the end of March 2026.
- Reduce community hospital and step-down care length of stay by more than 20 per cent compared to March 2024 levels, by the end of March 2026.
- Reduce respective HSCP delayed discharges by more than 20 per cent compared to March 2024 levels, by end of March 2026, because of improved flow.
- Less than 25 per cent of total delayed discharges in acute hospitals by December 2025.

116. The Scottish Government is working with the DwD group to ensure that all data reporting requirements and measures for monitoring are aligned.

Endnotes

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Appendix

Integration authorities' performance (number and rate of delays at the monthly census point) between October 2024 and October 2025

	October 2024		October 2025		
	Delays at monthly census point	Delays at monthly census point per 100,000 population	Delays at monthly census point	Delays at monthly census point per 100,000 population	Percentage change
Aberdeen City	64	33.8	49	25.9	-23.4%
Aberdeenshire	84	39.8	80	37.9	-4.8%
Angus	30	31.8	17	18.0	-43.3%
Argyll and Bute	33	44.8	53	71.9	60.6%
Clackmannanshire and Stirling	54	45.2	45	37.7	-16.7%
Dumfries and Galloway	79	65.3	101	83.5	27.8%
Dundee City	25	20.4	23	18.8	-8.0%
East Ayrshire	28	28.4	34	34.5	21.4%
East Dunbartonshire	27	30.7	24	27.3	-11.1%
East Lothian	38	41.2	31	33.6	-18.4%
East Renfrewshire	12	15.6	17	22.0	41.7%
Edinburgh	192	43.2	121	27.2	-37.0%
Eilean Siar	16	73.9	25	115.5	56.3%
Falkirk	65	50.2	68	52.5	4.6%
Fife	128	41.9	113	37.0	-11.7%
Glasgow City	231	42.8	252	46.7	9.1%

Cont.

Integration authorities' performance (number and rate of delays at the monthly census point) between October 2024 and October 2025

	October 2024		October 2025		
	Delays at monthly census point	Delays at monthly census point per 100,000 population	Delays at monthly census point	Delays at monthly census point per 100,000 population	Percentage change
Highland	223	114.2	215	110.1	**-3.6%**
Inverclyde	7	10.8	13	20.0	**85.7%**
Midlothian	32	40.5	20	25.3	**-37.5%**
Moray	33	42.7	38	49.2	**15.2%**
North Ayrshire	74	67.2	104	94.5	**40.5%**
North Lanarkshire	106	38.4	103	37.3	**-2.8%**
Orkney	7	38.7	15	82.9	**114.3%**
Perth and Kinross	47	37.1	46	36.3	**-2.1%**
Renfrewshire	20	13.0	9	5.8	**-55.0%**
Scottish Borders	84	86.9	43	44.5	**-44.8%**
Shetland	11	59.1	12	64.5	**9.1%**
South Ayrshire	79	84.8	88	94.5	**11.4%**
South Lanarkshire	124	45.9	107	39.6	**-13.7%**
West Dunbartonshire	24	33.3	53	73.5	**120.8%**
West Lothian	51	34.6	40	27.2	**-21.6%**
Scotland	**2030**	**44.8**	**1962**	**43.3**	**-3.3%**

Sources: Delayed discharges in NHS Scotland monthly, All delay reasons summary tables to October 2025, Public Health Scotland, December 2025. Mid-year population estimates for Scotland time series data, National Records of Scotland, August 2025

Delayed discharges

A symptom of the challenges facing health and social care

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