Scottish Care
Social care that works for Scotland

BEYOND THE HOSPITAL DOOR

Research report: November 2026



Making hospital transitions work for people and social care

Provider evidence on admission, time in hospital, discharge and return to support across Scotland's independent adult social care sector.

A successful transition is not simply a person leaving hospital.

It is one in which the person, their information, their support and responsibility for their care move safely together.

Executive summary

Hospital transitions are often discussed in terms of beds, flow and discharge. All of that matters, but it is not the whole experience. For the person moving between hospital and social care, a transition is also about whether the right information travels with them, whether those who know them are involved, and whether the support they need is ready when they arrive. These practical arrangements matter not only for safety and continuity, but for the confidence and reassurance that come from knowing the person is moving somewhere prepared to support them.

Scottish Care's Autumn 2026 survey of independent sector adult social care providers received 42 submitted responses. Forty respondents reported recent experience of admission and/or discharge transitions.

Collectively, respondents estimated that the services and organisations they represented supported approximately 2,384 adults through a hospital transition experience in the last year, giving an indication of the reach of the evidence and the scale of social care involvement in hospital transitions. A provider focus group then tested the emerging findings, explored variation and identified practical opportunities for improvement.

The findings do not point to one single point of breakdown. Respondents described difficulties with communication, recognition of changed needs, provider involvement, medicines, documentation, timing, equipment and follow-up. These issues are closely connected. Where several arise within the same transition, the effects are felt first by the person and those close to them, but also by the staff and service trying to support their return.

Leaving hospital is only one point in the journey. A successful transition is one in which the person is supported to return safely, with their choices understood, the right information available and clear responsibility for what happens next.

67%	**Around two in three respondents reported poor or delayed communication between hospital and provider at admission.** 22 of 33 respondents

77%	**More than three in four respondents reported limited communication or updates during the hospital stay.** 23 of 30 respondents

66%	**Around two in three respondents reported little or no advance notice of discharge.** 25 of 38 respondents

64%	**Almost two in three respondents reported anxiety, distress or confusion among impacts on people.** 21 of 33 respondents

79%	**Almost four in five respondents reported additional staff time chasing information or resources.** 26 of 33 respondents

Our priorities for change

The research points to a need for more consistent, joined-up approaches to hospital transitions, with clearer responsibility, better communication and greater recognition of social care's contribution. The following priorities provide a basis for improvement across national policy, local partnerships and everyday practice.

Creating shared foundations

- **Agree a minimum standard for safe transitions.** Establish consistent expectations across admission, hospital stay, discharge and follow-up, reflecting **compassion, communication and consistency**, while recognising the different realities of social care settings.
- **Strengthen shared responsibility.** Ensure health and social care partners have clear roles, with decisions, outstanding actions and accountability remaining connected around the person throughout their journey.
- **Improve information sharing.** Agree what information is needed, when and by whom, ensuring care plans, changed needs, medicines and follow-up arrangements are communicated effectively and existing systems are used wherever possible.

Making transitions work in practice

- **Recognise social care knowledge in decision-making.**Bring together clinical assessment with the knowledge held by the person, family and receiving provider about previous abilities, preferences, routines and support needs.

- **Confirm practical readiness before return.** Introduce a proportionate check that essential medicines, information, equipment, staffing and support arrangements are in place, with clear ownership of anything outstanding.
- **Strengthen escalation and learning.** Provide accessible routes for raising concerns, receiving feedback and identifying recurring issues, ensuring that experiences inform improvement rather than becoming lost between organisations.

Sustaining improvement

- **Evaluate and share local practice.** Build on approaches such as Trusted Assessor arrangements, feedback pathways and improved transfer documentation, understanding what works, why and under which conditions.
- **Involve independent providers from the outset.** Ensure social care expertise informs policy, planning and improvement, with appropriate recognition of the workforce, resources and clinical support needed to deliver additional responsibilities safely.
- **Measure successful transitions, not discharge alone.** Look beyond hospital flow to whether people are informed, their needs and choices are understood, support is ready and they experience continuity, dignity and confidence in what happens next.
- **Maintain action beyond publication.** Continue engagement between Scottish Care, providers, health and social care partners, people accessing support and families, using the evidence to inform improvement and share learning.

The overall ambition

A successful hospital transition should mean more than a person leaving hospital. It should mean that they are returning to support that is ready for them, with their needs understood, their choices respected and clear responsibility for what happens next.

Why this research was undertaken

The work began because Scottish Care members and colleagues were repeatedly raising concerns about the health and wellbeing of people supported by social care following hospital admission and discharge. Accounts shared through national member structures, Scottish Care's Strategic Nursing Group and local Independent Sector Lead activity described issues such as weight loss, pressure damage, missed medicines, inadequate rehabilitation, poor communication and difficulties raising concerns. It should be acknowledged that issues are more likely to be highlighted than successful experiences, and many instances of hospital transition will be positive.

This research therefore sought to understand experiences, impact and potential for learning and improvement. It is not able to assess the prevalence of issues, nor is it intended to attribute blame to individual staff or hospitals when highlighting challenges. It was developed to understand whether the experiences members were sharing pointed to wider and recurring systemic issues, and to build a clearer evidence base for practical improvement.

From discharge to the whole transition

Early discussion made clear that many problems began before discharge. Providers described delays and communication problems at admission, limited information during the hospital stay, exclusion from planning, uncertainty about changed needs and unresolved issues after return. The project was therefore broadened from exploring hospital discharge to the whole hospital transition experience.

This wider framing allows the research to look beyond simply whether a person left hospital. It asks what happened across the whole journey, whether the person and those supporting them were kept informed, what had changed, and whether the arrangements in place allowed support to continue safely and with dignity.

The Scottish policy and political landscape

Hospital transitions sit at the intersection of some of the most significant challenges facing health and social care in Scotland. Delayed discharge, hospital capacity, prevention, care closer to home and the future organisation of health and social care are often discussed separately. In practice, they are closely connected.

For Scottish Care, this research is particularly relevant because many of the ambitions now being set nationally depend on the capacity and expertise of social care. Supporting people to spend less time in hospital, recover at home and remain connected to their communities cannot be achieved through changes to acute services alone.

Delayed discharge: a symptom of wider system pressure

Delayed discharge remains one of the most visible signs of pressure across health and social care.

In 2024/25, people in Scotland experienced 720,119 clinically unnecessary hospital days due to delayed discharge. Audit Scotland's Delayed Discharges report estimated the cost of hospital days alone at more than £440 million a year, with delayed discharges accounting

for around one in nine hospital beds. Importantly, it described delayed discharge as a symptom of wider pressures across health and social care, rather than a problem that can be solved by hospitals alone.

The consequences are not only financial or operational. Remaining in hospital longer than necessary can affect mobility, independence, physical health and mental wellbeing. Equally, discharge which happens quickly but without the right support can create a different set of risks.

That distinction is important to this research. The findings suggest that the measure of a successful transition cannot simply be whether somebody has left a hospital bed. Among respondents to Scottish Care's survey, issues around communication, changed needs, provider involvement, medicines, information, equipment and timing were all reported at the point when people were moving back into social care.

The challenge is therefore to reduce unnecessary delays without creating unsafe or poorly supported transitions.

Improving flow and strengthening care closer to home

The Scottish Government's Health and Care Improving Flow Plan 2026-2031 sets an ambition for one connected system, with simpler routes to care, fewer unnecessary hospital stays and more support delivered in people's homes and communities. It explicitly frames improving flow as being about people rather than organisational processes or targets. That direction is welcome, but it also has significant implications for social care.

A shift towards prevention, earlier discharge and more care closer to home means that a greater level of need and complexity will be supported outside hospital. Scottish Care's 2026 Nursing Workforce Survey Report reached a similar conclusion: 96.55% of respondents reported increasing complexity or acuity, reinforcing that community-based care is already changing. The ambition to move care closer to home therefore needs to be considered alongside the capacity required to make that possible.

For hospital transitions, that means asking practical questions. Is the receiving service involved early enough? Is information available? Are medicines and equipment in place? Has changed need been understood? Is the person's established support able to continue?

These are not secondary considerations after a decision to discharge. They are part of what makes discharge possible.

A practical test of public service reform

Scotland's Public Service Reform Strategy identifies prevention, joined-up services and efficiency as central to reform and recognises the need to address systemic barriers which make it harder for services to work around people.

Hospital transitions provide a practical example of why that matters. Where information has to be repeatedly requested, separate organisations work to different processes, providers are brought into planning late, or responsibility becomes unclear between services, the result can be inefficient for the system and difficult for the person experiencing it.

The focus group discussion reinforced this. Participants described parallel local processes, different reporting routes, incompatible information systems and situations where providers struggled to identify who held responsibility for a concern. At the same time, examples from Highland, Perth and Kinross, Lanarkshire and Tayside showed local partners

attempting to address exactly these problems through a range of mechanisms including feedback loops, Trusted Assessor arrangements, clearer escalation pathways and more consistent documentation.

There is therefore a wider reform question behind the individual findings: how can responsibility be shared more effectively around the person, rather than repeatedly transferring between organisations as the person moves through the system?

Social care within a changing system

That question has particular significance as Scotland considers the future shape of health and social care.

The Independent Review of Adult Social Care called for a shift away from crisis towards prevention and wellbeing and placed human rights, lived experience, collaboration and fairness at the heart of reform. It also recognised that most social care is delivered in communities and people's own homes, and argued for that direction to continue.

More recent reform discussions continue to focus on ongoing challenges around fragmentation, accountability, consistency and the relationship between health and social care. However, there is strong consensus around the need for earlier support, easier navigation, continuity, better coordination and preserving social care's distinct focus on independence, quality of life, participation and community connection.

Scottish Care's recently published Framework for the Reform of Social Care in Scotland takes this further. It argues that health and social care have complementary rather than interchangeable purposes: healthcare has key roles in diagnosis, treatment and clinical intervention, while social care enables people to live, belong, choose, maintain relationships and participate in their communities. It also identifies provider partnership, continuity, community capacity and accountability across the whole pathway as important tests of reform.

When someone leaves hospital, the question is not simply whether health care has ended and social care has begun. For the person, there should be continuity between the two.

The research presented here therefore has relevance beyond hospital discharge. It provides evidence about what integration and shared responsibility look like at one of the points where different parts of the system most directly meet.

WHY THIS EVIDENCE MATTERS NOW

Scotland's ambitions around prevention, hospital flow and care closer to home increasingly depend on what happens outside hospital. The capacity, knowledge and sustainability of social care therefore need to be part of those ambitions from the outset, rather than considered only once somebody is ready to leave.

About the research

Survey

The online survey ran from 4 to 20 September 2026 and received 42 submitted responses. Forty respondents reported recent experience of hospital admission and/or discharge involving people supported by their service. Respondents included care home, care at home and housing support perspectives, with care homes forming the largest group (76% of responses related fully or in part to care home service provision).

Based on respondents' estimates, the survey captures hospital transition experience relating to approximately 2,384 adults across the responding services and organisations. While this is not an exact count of unique individuals, it provides an indication of the scale at which independent social care services are involved in hospital admissions, discharges and the wider transition process.

Importantly, this figure reflects the range of hospital transition experiences reported, whether positive, negative or neutral. It should not be interpreted as the number of people who experienced difficulties, nor as the total number of adults supported by the responding services.

Question bases differ because of routing, missing responses and questions which were not applicable to every respondent. Counts and the relevant valid base are used throughout. For multiple-response questions, percentages can total more than 100%. The findings are unweighted provider evidence and should not be interpreted as prevalence estimates for every hospital transition in Scotland.

Focus group and examples

A transcribed focus group with 16 Scottish Care members and local sector representatives was held in October 2026. Its role was to explore the emerging survey findings in greater depth: to add explanation, examine variation and identify potentially useful practice. Focus group accounts are used to interpret the reported problems and illustrate how they may arise or be addressed; they do not independently verify individual experiences or establish how common an experience is.

The evidence through four journeys

The following journeys bring individual reported experiences alongside the wider survey findings. They are not presented as representative of every transition. Their value is in showing what some of the issues recorded in the survey can mean for a person, their family and the staff and organisations supporting them. The sections that follow then bring the full findings together across admission, time in hospital, discharge and return to support.

When several failures accumulate

The experience

One respondent described a person admitted to hospital with aspiration pneumonia who was already clinically frail. Five days later, the person returned to the care home with limited transfer information.

The respondent reported that the person's usual medicines had not returned, while antibiotics were attached to the paperwork without instructions.

The person returned with a catheter that had not previously been in place, had lost 3kg and had significant pressure damage which the provider said had not been communicated.

The respondent described the experience as a "really poor discharge and admission".

The impact extended beyond the practical work required on return. The respondent also reported that the person's daughter regretted the decision to seek hospital treatment.

Survey case example. Identifying details have been removed. The experience and clinical details are reported by the respondent and have not been independently verified.

This experience in the wider findings

This was a particularly concerning account, but several of its elements appeared more widely in the survey. Among the 38 respondents answering the discharge questions, 25 (66%) said changed needs or dependency had not been clearly recognised or planned for; 25 (66%) reported little or no advance notice; 24 (63%) identified discharge at an unsuitable or unsafe time; 22 (58%) reported late, incomplete, inaccurate or unavailable information; 22 (58%) said the provider had not been involved early enough; and 20 (53%) reported incomplete, inaccurate or unexplained medication changes.

These figures come from a multiple-response question and should not be read as separate groups of people. Rather, they show how several problems could be experienced within the same transition.

What this meant for the person

Returning home or to a care setting should be a point at which someone can begin to settle again after a hospital stay. In this example, the provider was instead trying to understand several significant changes after the person had already returned. Questions about medicines, a new catheter, weight loss and pressure damage all had to be addressed at the same time.

There is an obvious safety dimension, but it is also about how someone experiences that return: whether pain is recognised, whether they are comfortable, whether staff understand what has changed and whether those close to them have confidence in what will happen next. The person had left hospital, but the transition was not complete.

What would have helped

A safer approach would confirm before departure that changed health and support needs, medicines, wounds, equipment and follow-up are understood. The person and family should know what is happening, the receiving provider should have enough information to prepare, and responsibility for anything unresolved should be clear. This may require a concise readiness check, but the value would lie in the conversations and actions behind it rather than in the form itself.

When “back to baseline” does not mean back to the life the person knew

The experience

A provider prepared for a person’s return on the understanding that the person used a stand aid.

When the person returned, the provider found that a hoist was required.

The respondent also reported that the person’s pain was not adequately controlled. A

sked what might have reduced the impact, the respondent called for better communication and “honest information” about the equipment being used and the person’s pain.

Survey case example. The account is presented as reported by the respondent.

Changed need was one of the clearest findings

Among 38 respondents answering the discharge questions, 25 (66%) reported that changed needs or dependency were not clearly recognised or planned for. Twenty-two (58%) said the provider had not been involved early enough.

The same issue was visible during the hospital stay. Of 30 respondents, 23 (77%) reported limited communication or updates, 22 (73%) difficulty obtaining information about likely discharge and 19 (63%) said planning did not include the provider or appeared not to reflect the person’s previous needs, preferences or routines.

What do we mean by baseline?

The difference between a stand aid and a hoist changes the equipment, space, staffing and moving-assistance arrangements needed to support the person safely. Clear information and communication can help ensure that the person is supported comfortably and with dignity from the moment they return.

The case also raises an important question about what is meant by “baseline”. That judgement is difficult without knowing how the person moved, communicated, made choices and lived before admission. Clinical assessment is essential, but so too is knowledge of the person’s ordinary life.

Involving the provider is not about one professional group seeking control. It is about

ensuring that the person's established life, preferences and support relationships remain visible in decisions. Where that knowledge is absent, a discharge may be clinically possible but still leave important questions about choice, continuity and independence unanswered.

A better question at discharge

The question should move beyond "Is the person back to baseline?" It should ask: "What was this person's life and support before admission, what has changed, what matters to them and what is now required for a safe and dignified return?" The person, family and receiving provider should contribute where relevant, particularly when the person may find it difficult to communicate or advocate for themselves.

The transition begins before the hospital door

The experience

One respondent described waiting five hours for a care review.

When the review was completed, the situation was marked urgent.

The respondent was told to expect paramedics within an hour but reported a further seven-hour wait, followed by another seven hours in the emergency department.

The respondent said better communication with emergency services, the person and family, and greater recognition of provider input would have reduced the impact.

Survey case example. Waiting times are those reported by the respondent.

The wider admission picture

The waiting times in this account are an individual experience, but admission difficulties appeared more widely. Among 33 respondents answering admission questions, 22 (67%) reported poor or delayed communication between hospital and provider, 18 (55%) reported delays in assessment, response or handover, and 17 (52%) said hospital staff had not sought or used information held by social care staff.

Communication problems continued after admission. During hospital stays, 23 of 30 respondents (77%) reported limited updates and 22 (73%) difficulty obtaining information about likely discharge arrangements.

One journey across several services

A care review, ambulance response and emergency department may sit within different services and performance frameworks. For the person waiting, however, they form one journey. Long periods of uncertainty can be particularly difficult for someone living with dementia, frailty, a learning disability or communication needs, and for the staff or family members trying to support them.

Staff may know what is usual for the person, how they communicate pain or distress, which medicines have already been taken and what helps them make decisions. That knowledge does not become less relevant when the person enters hospital. The findings raise a question about how consistently it is carried into assessment and onward planning.

Keeping knowledge connected

Communication responsibility should apply across the whole journey, including urgent response and admission. At each stage, the system should ask what is already known, who holds essential knowledge, what the person understands, what the next stage requires and who is responsible for keeping the person and those supporting them informed.

When the system works around the person

The experience

One focus group account illustrated how shared assessment before discharge could connect clinical decisions with practical readiness at home.

A provider's bedside assessment enabled direct discussion with nurses, doctors, occupational therapists and physiotherapists about the person's condition, support and equipment.

A visit to the person's home then identified what was available and what was missing.

A named nurse remained available if the return home did not work as planned.

Within this reported experience, assessment, preparation and follow-up were connected rather than left as separate tasks.

The participant described the pathway as "like a dream" and said there was "true ownership and accountability".

The participant was equally clear that this was an exceptional rather than routine experience.

Focus group example, presented anonymously. It illustrates potentially useful practice conditions but is not evidence of prevalence or a formally evaluated intervention.

Why this example matters

The example provides a useful contrast to some of the survey's strongest findings. Instead of being contacted once a decision had been made, the provider was involved early enough to contribute. Hospital staff brought clinical information, the provider brought knowledge of what could be delivered at home, the environment and equipment were considered, and there was a named contact if difficulties arose.

The person's home was not treated as an abstract destination. What would be needed for the person to live there safely, with dignity and as much independence as possible formed part of the decision.

What could be made routine

One example cannot tell us which model should be used everywhere. It does, however, identify conditions worth testing more widely: early involvement, shared knowledge, practical preparation, named responsibility and access to follow-up. The challenge is to make these less dependent on individual relationships or exceptional effort.

What respondents reported across the whole journey

The illustrated journeys show how different issues can come together in practice. The wider survey findings show that concerns were reported at each stage. They also suggest that communication, information, involvement and readiness cannot be treated as isolated parts of the process.

Admission: knowledge was not always sought or carried forward

67%	**Around two in three respondents reported poor or delayed communication between hospital and provider.** 22 of 33 respondents

55%	**reported delays in assessment, response or handover.** 18 of 33 respondents

52%	**said hospital staff had not sought or used information held by social care staff.** 17 of 33 respondents

More than half of those answering the admission questions reported each of these issues. The findings do not tell us that every admission was difficult, but they do show that providers frequently encountered points at which information or professional knowledge was not travelling with the person.

During the hospital stay: providers struggled to remain connected

77%	**More than three in four respondents reported limited communication or updates during the hospital stay.** 23 of 30 respondents

73%	**reported difficulty obtaining information about likely discharge arrangements.** 22 of 30 respondents

63%	**reported exclusion from planning or decisions made without full knowledge of previous needs, preferences or routines.** 19 of 30 respondents

This raises a question about how consistently relevant knowledge from different settings is being brought together. A provider may not need every clinical detail, but they do need enough information to prepare, contribute to planning and maintain continuity for the person.

Discharge and return: several issues often sat together

66%	**Around two in three respondents reported little or no advance notice of discharge.** 25 of 38 respondents

66%	**Around two in three respondents reported needs or dependency not clearly recognised or planned for.** 25 of 38 respondents

63%	**reported discharge at an unsuitable or unsafe time.** 24 of 38 respondents

A further 22 of 38 reported insufficient provider involvement, 22 reported late or incomplete information and 20 reported problems around medication changes. These were multiple-response questions, so the findings indicate that one transition could involve several of these issues at once.

A WORSENING EXPERIENCE WITHIN THE RESPONDENT GROUP

Eighteen of 33 respondents answering about admissions said admission-related issues had increased compared with the previous six months. For discharge, 21 of 38 reported an increase in discharge-related issues. This is not evidence of a universal Scotland-wide trend, but it is a signal of worsening experience among those respondents.

When a difficult transition becomes a human experience

The survey asked respondents about the effects they had seen on people supported by their services. These findings deserve space in their own right. They show why hospital transitions cannot be reduced to whether a bed has been released or a form completed.

64%	**Almost two in three respondents reported anxiety, distress or confusion.** 21 of 33 respondents
58%	**reported delay in receiving care, support or reablement.** 19 of 33 respondents
52%	**reported loss of confidence or trust.** 17 of 33 respondents
39%	**reported pain, discomfort or deterioration.** 13 of 33 respondents
39%	**reported medication-related risk.** 13 of 33 respondents

Confusion and distress are not side effects of the process

A hospital admission can already be unsettling. Limited information, unfamiliar settings,

long waits and sudden changes can add to that uncertainty. For a person living with dementia, a learning disability, frailty or communication needs, disruption to routine and separation from familiar people may make it more difficult to understand what is happening or express discomfort.

Respondents particularly identified people living with dementia, people without family or informal support, people living with frailty and people who require specialist equipment among those they believed could be more affected. These selections are not comparative risk estimates, but they show where providers saw particular concern.

Delay can change what remains possible

The significance of delay is not captured by elapsed time alone; it also concerns what opportunities remain available to the person. For someone waiting for reablement, delay may affect the opportunity to regain confidence or independence. For a person approaching the end of life, it can remove a limited opportunity to return home or to the place where they wish to be cared for. Focus group accounts added this time-sensitive dimension to the survey finding on delayed care, support or reablement, suggesting that transition measures need to consider the consequences of waiting as well as its duration.

Choice and continuity can also be lost

Continuity after hospital admission may depend not only on discharge arrangements but also on whether established support remains available. Focus group accounts described care at home packages being interrupted, reassessment being triggered and people moving into different funding arrangements without clear communication. These accounts suggest a potential route through which admission can affect provider choice, delay the return of support and separate someone from staff who know them. The survey did not explore this issue extensively enough to quantify it, making it an emerging finding for further investigation rather than an established pattern across services.

The findings do not establish that every reported difficulty resulted in harm, nor do they provide direct testimony from people using services. They do, however, show that providers associated difficult transitions with impacts on comfort, confidence, independence, dignity and wellbeing. Those experiences need to be part of how success is measured.

When the consequences may be particularly significant

The survey also asked providers whether they felt particular groups of people were more likely to be affected by difficulties during hospital transitions.

People living with dementia were identified most frequently, by 23 of the 33 respondents (70%) answering this question. Respondents also highlighted people without family or informal support (39%), people living with frailty (36%) and those requiring specialist equipment (33%). People with learning disabilities, physical disabilities and those receiving palliative or end-of-life care were each identified by 30% of respondents.

These findings do not establish that these groups experience a higher rate of poor transitions. Rather, they provide an indication of where respondents felt the consequences could be particularly significant.

For someone living with dementia, unfamiliar surroundings, disrupted routines or limited

communication may make it more difficult to understand what is happening. For someone without family or informal support, there may be fewer opportunities for concerns to be raised or important information to be shared. Where specialist equipment or substantial physical support is required, incomplete planning can have immediate practical implications for whether a person can return safely.

The focus group discussion also raised concerns about transitions involving people with learning disabilities and those approaching the end of life, particularly where delays, changing support arrangements or assumptions about the receiving setting could affect choice and continuity.

What these experiences have in common is the importance of understanding the individual rather than relying on a standard process alone, and of the role of advocacy. The person's communication needs, preferences, existing relationships and support arrangements all matter in determining what a safe and dignified transition looks like.

The hidden work transferred into social care

When information, medicines or practical arrangements are incomplete, the work required to resolve them does not disappear. Respondents described staff spending time chasing information, sourcing medicines or equipment, reorganising rotas and supporting people through distress or uncertainty.

79%	**Almost four in five respondents reported additional staff time chasing information or resources.** 26 of 33 respondents
58%	**reported out-of-hours disruption.** 19 of 33 respondents
52%	**reported additional administration.** 17 of 33 respondents
48%	**reported staff stress or reduced morale.** 16 of 33 respondents

This matters not only for providers. Time spent reconstructing a transition is time that cannot be used elsewhere, and 42% of respondents reported disruption to support for other people. The findings indicate that unfinished transition work can affect the wider service, particularly where it arrives unexpectedly or outside normal working hours. This creates both a fiscal and a human impact.

Different settings have different practical realities

The focus group repeatedly returned to the need to understand the setting to which someone is returning. A care home is not a hospital ward and does not hold an equivalent stock of medicines, continence products or clinical equipment. Care at home services work through planned visits and geographically dispersed staff. Supported living is someone's own home and may not provide continuous staffing or nursing care.

A process which treats these settings as interchangeable can result in assumptions about what is available, who will be present and what level of need can be safely supported. Greater consistency should therefore mean consistency in the essentials, not a single inflexible process that ignores the destination.

When concerns are raised, providers need to see what happens next

Formal concern-reporting systems may not capture the full range of transition problems experienced by providers. Focus group accounts identified barriers that help explain this potential gap: uncertainty about where to report, repeated submission of information through different systems and limited feedback after escalation. Staff may lack time to record an incident, managers may not be present when it occurs, and some systems are inaccessible to independent providers. These accounts do not establish the extent of under-reporting, but they show why an absence of formal reports cannot be treated as evidence that poor transitions are not occurring.

This can affect trust. Providers may continue to report concerns because they have a responsibility to the person and family, but without acknowledgement or visible learning it is difficult to know whether the same issue is being prevented elsewhere.

A USEFUL PRINCIPLE FROM THE FOCUS GROUP

Escalation should not be designed around blame. It should make concerns recordable, provide acknowledgement and response, and allow people, families and services to see how learning leads to change.

What helps a transition work well

The evidence was not solely about what went wrong. Respondents and focus group participants also described conditions and local approaches that may support better transitions. These examples are at different stages of development and should not be treated as evaluated solutions. They do, however, provide practical learning.

Early provider involvement

The positive bedside-assessment example showed what changed when the provider was involved before discharge rather than contacted once the decision was already urgent. Direct discussion with hospital professionals, valuing social care professional assessments and expertise, understanding the home environment and agreeing a named contact created a more planned return. The survey finding that 58% of respondents felt providers were not involved early enough gives this example wider relevance.

Care Home Trusted Assessor arrangements

Care Home Trusted Assessor arrangements, piloted and now made permanent in Perth & Kinross Health & Social Care Partnership, offer a useful practice example of early provider involvement, shared assessment and greater confidence in discharge planning.

One survey respondent reported a positive pre-admission experience involving a Trusted Assessor and full provider involvement. Focus group participants described the Perth and Kinross Care Home Trusted Assessor role as having moved to a permanent arrangement following positive experiences of the pilot. They also reported that participation by care homes had continued to increase and described benefits for people moving from hospital, care home managers and staff.

Participants reported that four partnerships had since adopted versions of the approach, although the way each model operates may differ and a dedicated post may not be equally affordable in every area.

This research was not designed as a formal evaluation of the Trusted Assessor model, so it cannot assess or compare its outcomes systematically. However, the survey and focus group evidence provide a positive account of its contribution in Perth and Kinross, particularly in improving communication, supporting provider confidence in assessment and helping care homes make informed decisions about whether they can meet a person's needs. The experience provides a strong basis for further shared learning, including how the model operates, the outcomes being achieved, the conditions which have supported its development and which elements may be transferable to other areas.

Highland: making concerns visible and creating a feedback loop

Work in Highland, developed through Scottish Care's Independent Sector Lead in partnership, illustrates an attempt to connect provider concerns with a defined route for response. Focus group accounts described collaborative work between acute services and care homes, initially focused on one hospital. Engagement with ward staff addressed the practical realities of care homes, while feedback forms and an accessible email route provided ways to raise concerns as well as to give feedback on positive experiences. An expected response from charge nurses within 72 hours gave the process a stated point of responsibility and response timeframe.

With a focus on learning and improvement, the Highland work aims to generate formal data, feedback and accountability as well as resolve individual concerns. Whilst implementation was reported as remaining inconsistent in part across care homes and wards, extension to other hospitals is now under development. Further progression to include care at home services is actively being considered collaboratively. This suggests that whilst establishing a reporting route is part of the picture, consistent uptake and coverage also need attention and this is being actively addressed.

Lanarkshire: transfer information and escalation

Across North and South Lanarkshire, focus group participants described several connected areas of improvement work. These included a revised hospital-to-community transfer document, which remains under review, a care home concern escalation pathway and a medication assessment tool developed for care at home services. The work brings together two important parts of the transition: the information available when a person moves between hospital and community support, and the route through which providers can raise concerns when arrangements have not worked as intended. The care home escalation pathway is intended to make concerns more consistently recordable and capable of being acted upon. The transfer document and medication assessment work are intended to support clearer and more usable information across services. As these approaches remain at different stages of development, the research cannot yet assess their reach or impact. They nevertheless provide useful examples of local partners seeking to address recurring issues identified through the survey, particularly around information transfer, medicines, communication and follow-up.

Local innovation needs shared learning

Across the local examples, partnerships were attempting to address recurring problems in parallel: information transfer, provider involvement, escalation and feedback. Focus group accounts raised a further concern about how easily ideas could be shared and adapted between areas. Taken together, these examples support a case for national learning and common expectations, alongside evaluation of which approaches work, for whom and under what conditions. Such learning needs to preserve the local relationships and practical knowledge on which implementation depends.

WHAT GOOD PRACTICE HAS IN COMMON

Across these examples, the recurring features were early involvement, usable information, recognition of social care knowledge, practical preparation, a named point of responsibility, access to follow-up and a way to learn when something goes wrong.

Compassion, communication and consistency

Compassion, communication and consistency provide an organising framework for the connected findings on people's experiences, information sharing and variation in practice.

Compassion

Compassion means recognising the person in the process: what it is like to return late at night, to wait without clear information, to experience pain or confusion, or to lose a limited opportunity to return home at the end of life. It is shown through timing, explanation, respect for choice and attention to dignity.

Communication

Communication is not simply the transfer of a document. It includes listening to the person and those who know them, keeping relevant people informed, using the information already available and making clear who owns the next step. There is also a question about how shared information could better support this continuity, including through a citizen-controlled data platform. Any such approach would need to be developed with people using services, with clear arrangements for consent, privacy and appropriate access. Its value would lie in supporting the conversations and decisions around the person, rather than replacing them.

Consistency

Consistency means that essential expectations do not depend on geography, an individual member of staff or a short-lived initiative. It does not require every setting to work in exactly the same way. It requires a reliable minimum standard, supported by training, ownership, review and shared learning.

These three principles provide a useful thread through the findings. Compassion keeps the focus on the person. Communication connects the knowledge around them. Consistency makes safer practice less dependent on chance.

What the evidence means for action

The findings do not point to one intervention which will resolve every issue. They suggest a need for more consistent and coordinated approaches to hospital transitions, with clearer expectations around communication, involvement, responsibility and practical readiness. While individual improvements to documentation or discharge processes are important, the research suggests that these need to sit within a wider understanding of what a successful transition should mean for the person.

The recommendations below are intended to support practical improvement at national, partnership and service level. They draw on the survey findings, the experiences explored through the focus group and examples of local practice already being developed. They should be taken forward collaboratively, with people who access care and support, families, social care providers, NHS partners and Integration Authorities, recognising the different responsibilities, pressures, lived experiences and contributions of those involved and

impacted.

Creating shared foundations

1. Agree a shared minimum standard for safe hospital transitions

The Scottish Government, NHS Boards, Integration Authorities, Health and Social Care Partnerships and independent social care representatives should work together to agree a practical minimum standard for hospital transitions, covering admission, time in hospital, discharge and immediate follow-up.

This should establish consistent expectations around communication, provider involvement, recognition of changed needs, medicines, documentation, equipment, timing, transport and follow-up arrangements. It should also reflect the principles of compassion, communication and consistency identified through the focus-group discussion.

A shared standard should provide clarity about what needs to happen, while allowing sufficient flexibility to reflect the circumstances of the person and the different realities of care homes, care at home, housing support and supported living. Consistency should not mean assuming that all receiving settings have the same staffing, resources or clinical capacity.

2. Strengthen shared responsibility and accountability around the person

The research raises a wider question about how responsibility is shared across health and social care as people move between services.

NHS Boards, Health and Social Care Partnerships, Integration Authorities and independent providers should establish clearer expectations around their respective roles throughout the transition process. This includes how decisions are made, when providers should be involved, who is responsible for progressing outstanding actions and how continuity is maintained when someone moves between organisations.

Shared responsibility should not mean that accountability becomes less clear. Rather, there should be a common understanding of what each organisation is responsible for, alongside arrangements that ensure important actions and information are not lost between different parts of the system.

The aim should be to maintain responsibility around the person, rather than repeatedly transferring it as they move through the hospital journey.

3. Establish a shared approach to information and communication

The survey identified communication and information sharing as recurring concerns across admission, hospital stays and discharge. Improving this requires more than introducing additional documents or systems.

NHS Boards, Health and Social Care Partnerships and independent providers should agree what information is essential at different stages of the transition, how it should be shared and who is responsible for ensuring that it reaches the people who need it.

This should include relevant care plans, medicines information, changes in health or support needs, discharge arrangements and follow-up requirements. Information should be timely, accurate, accessible and relevant to the care and support being provided.

Importantly, there should also be greater recognition of why social care providers require this information. It enables them to prepare appropriate support, understand changes in the person's needs and maintain continuity, rather than simply fulfilling a documentation requirement.

Where possible, improvement should build on existing digital and information-sharing arrangements, avoiding further duplication. However, progress on digital systems should not delay practical improvements to communication and professional relationships.

Making transitions work in practice

4. Make social care knowledge part of readiness decisions

Decisions about whether someone is ready to return home or to a care setting should draw on the knowledge of the person, their family where appropriate, and those who supported them before admission.

Hospital and discharge teams should ensure that this knowledge informs assessments of the person's previous abilities, routines, preferences, changed needs and practical support requirements.

This is particularly important where a person has experienced changes in mobility, cognition, communication or dependency, or where their support arrangements may need to change.

The purpose is not to prioritise one professional perspective over another, but to bring together clinical knowledge and an understanding of the person's ordinary life. This would help ensure that decisions about readiness reflect not only someone's medical condition, but also the circumstances and support available in the setting to which they are returning.

5. Introduce a proportionate pre-return readiness check with clear ownership

Before a person leaves hospital, there should be a clear and proportionate process for confirming that the practical arrangements needed for their return are in place.

This should include, where relevant, medicines and prescriptions, discharge information, changed care or support needs, equipment, transport, expected arrival time and immediate follow-up arrangements.

An identified professional should have responsibility for confirming that these matters have been considered and for ensuring that any outstanding actions have a clear owner.

The intention should not be to introduce another disconnected form or administrative process. Instead, this should provide a practical means of ensuring that the person, their family and the receiving service have the information and support required for a safe and dignified return.

Where standard documentation or checklists are introduced, attention must also be given to implementation, training and ongoing use. The focus-group evidence highlighted that introducing a process does not necessarily mean it will be used consistently or achieve the intended improvement.

6. Establish accessible routes for escalation, response and learning

Providers should have a clear and accessible means of raising concerns about hospital transitions, with confidence that these will be acknowledged, reviewed and used to inform improvement.

This should not depend on access to NHS-only reporting systems or require providers to submit the same information through several disconnected processes.

There should be clearer expectations around responses and feedback, including how providers, and where appropriate the person or family, are informed about what has happened following a concern.

Alongside individual escalation, a more consistent approach to recording and reviewing transition-related concerns across health and social care would help identify recurring issues, understand where improvement is needed and make learning more visible.

This should include positive experiences and examples of effective practice, rather than focusing solely on incidents or difficulties.

Sustaining improvement and accountability

7. Evaluate, connect and share local practice

The research identified a range of local initiatives seeking to improve hospital transitions, including Trusted Assessor arrangements, feedback and escalation pathways, transfer documentation and medication-assessment tools.

These provide important opportunities for shared learning, but approaches are at different stages of development and may operate differently across partnerships.

National and local partners should work together to better understand how these initiatives are being used, what outcomes they are achieving and which elements may be transferable to other settings.

Evaluation should consider not only safety and timeliness, but also the experience of people and families, provider involvement, workforce impact, cost, sustainability and the conditions that have enabled an approach to work.

There is also value in understanding the relationships, leadership, capacity and culture that support successful local improvement. Sharing these insights could help other partnerships build on existing work rather than repeatedly developing separate approaches to similar problems.

The aim should be to support national learning and greater consistency while protecting the flexibility and local relationships that make improvement possible.

8. Strengthen independent provider involvement in policy, planning and delivery

Independent social care providers should be involved from the outset in national and local work on hospital flow, information sharing, discharge planning and service improvement.

Their professional knowledge and understanding of the people they support should be recognised as part of the wider system's expertise.

This should include opportunities for joint learning between health and social care colleagues about the roles and responsibilities of different services, what care homes, care-at-home services, housing support and supported living can safely provide, and why particular information or clinical support may be required.

Where changes to hospital pathways place additional expectations on social care providers, these should be accompanied by consideration of the workforce, training, equipment, clinical governance, funding and access to professional advice required to deliver them safely.

This is important both for the sustainability of services and for ensuring that people return to support that is appropriately prepared for their needs.

9. Develop a shared understanding of successful hospital transition

The findings suggest that different parts of the system may not always be working towards the same understanding of what constitutes a successful discharge. Performance measures should therefore consider more than whether someone has physically left hospital or whether a bed has become available.

A fuller understanding of success would include whether the person and those supporting them were kept informed, whether their needs and preferences were understood, whether the receiving service was involved, and whether the necessary medicines, information, equipment and support were available.

It should also consider what happens after return, including continuity of support, avoidable escalation or readmission, and the person's experience of safety, dignity, confidence and independence.

Developing this shared understanding would provide a stronger basis for evaluating improvement across the whole transition, rather than measuring success within individual organisations alone.

10. Maintain engagement and action beyond publication

The findings provide a starting point for further work rather than a complete account of every experience or solution.

Scottish Care should continue to bring together providers and relevant partners to consider the implications of the research, support local and national improvement and share learning as practice develops.

This should include further engagement with people who access care and support and their families, whose direct perspectives were not captured through the provider survey.

Their experiences will be important in understanding what successful transitions mean in practice.

There is also an opportunity to connect this work with existing national programmes on hospital flow, information sharing and social care reform, ensuring that the evidence gathered through the research contributes to wider discussions and decisions.

Maintaining this engagement would help ensure that the report becomes part of a continuing process of improvement, with opportunities to understand what changes, what works and where further action is needed.

Conclusion

Hospital transition is one of the places where Scotland's ambitions for joined-up, preventative and person-led care are tested in everyday practice.

The survey findings show recurring concerns across admission, time in hospital and discharge. Communication is often limited; providers are not always involved or able to contribute what they know; changed needs, medicines and practical readiness can remain uncertain; and respondents associated difficult transitions with confusion, distress, delay, loss of trust and additional risk for the person.

The findings also raise a wider question about how responsibility, information and learning are shared across health and social care. Improving individual discharge processes will be important, but it is equally necessary to ensure that relevant knowledge remains connected around the person, that responsibilities are clear and that concerns lead to learning across organisational boundaries. These are practical foundations for more consistent and person-centred hospital transitions.

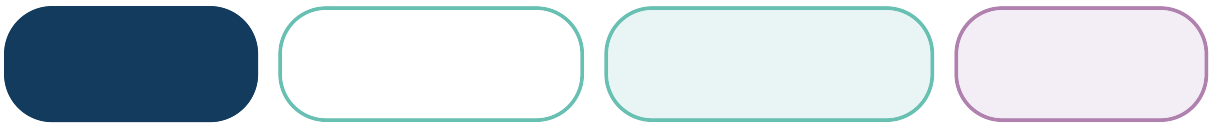
The evidence also shows that a different experience is possible. Early involvement, direct communication, practical preparation, named responsibility and follow-up can make the return home or to a care setting more planned and more secure. Local examples show useful work already under way, but also the need for better evaluation, shared learning and consistency across areas.

Read together, the findings can be organised around compassion, communication and consistency. Compassion keeps attention on the person rather than the process. Communication brings together the knowledge needed to support them. Consistency helps ensure that safe practice does not depend on where someone lives, who happens to be on duty or whether a local initiative has retained momentum.

Success should therefore be judged not only by whether the person has left hospital, but by whether they arrive in the right place with their choices understood, their support ready, the necessary information available and clear responsibility for what happens next.

THE MEASURE OF SUCCESS

The person is in the right place, the support is ready, those involved understand what has changed and responsibility for the next steps is clear.



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About Scottish Care

Scottish Care is the representative body and voice of the independent social care sector in Scotland. We are a membership organisation, thinktank and social care futures designer, working to ensure that social care is valued, visible, viable and visionary.

Our membership brings together independent care and support providers delivering services across Scotland, including care homes, nursing care, care at home, housing support and day care. These services support people with a wide range of needs and circumstances, enabling independence, choice, dignity and participation in everyday life.

We work locally and nationally to support our members, influence policy, share research and evidence, and contribute to the development of high-quality, sustainable social care. Through collaboration with providers, the workforce, people accessing care and support, policymakers and partner organisations, we seek to strengthen understanding of social care's distinctive contribution to Scotland's communities.

Research and engagement are central to this work. By bringing together the experiences and knowledge of independent providers, we aim to make the realities of delivering care and support more visible, identify opportunities for improvement and ensure that the sector's voice informs decisions about the future of health and social care.

Our work is grounded in the belief that social care is about much more than meeting practical needs. It supports people's rights, relationships, wellbeing and ability to live their lives with choice and dignity. We advocate for a system that recognises this contribution, values those who provide care and support, and creates the conditions for compassionate, sustainable and person-led care.

Our goal is social care that works for the people of Scotland.

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Scottish Care is a registered Scottish charity (SC051350), regulated by the Scottish Charity Regulator (OSCR).

Report notes: limitations

The voluntary, unweighted survey does not estimate prevalence across all hospital transitions in Scotland.

The findings primarily reflect provider perspectives and do not directly capture the views of people using services, families, hospital staff or commissioners.

Question bases vary and every figure should be read with its denominator.

Individual accounts illustrate findings but do not establish how common an experience is.

Reported harms and clinical details have not been independently verified.

Small and overlapping geographical groups do not support rankings or robust local comparison.

The focus group provides explanation and practice insight, not prevalence evidence.

Local good-practice examples are at different stages of development and have not been formally evaluated through this research.