Hospital Discharge Report: Care Providers' Perspectives

Autumna

August 2024

Foreword

As the UK's largest and most comprehensive directory of later-life care providers, we knew there was widespread discontent among care providers with the hospital discharge system. Our survey quantifies the frustration experienced by care providers, identifying key reasons for delayed discharge. Moreover, it provides evidence to inform national policy to improve the current system, so our elderly get the care and support they need, when they need it. This, in turn, will help to alleviate the strain on hospitals and reduce the financial burden on the public purse.

The responses reveal a shocking, and alarming, disconnect between the NHS and social care, with 93% of over 550 care providers questioned calling for the government to reform the system. Surprisingly, 85% of care providers who say they have a positive relationship with hospital discharge teams also support top-down reform.

Poor communication and information are common themes that mean elderly patients are stuck in hospital when they don't need to be, often finally being discharged to a care provider who cannot meet their needs. Nearly half of care providers told us the information provided by discharge teams is not accurate, with a similar number saying the information provided is insufficient to make an initial assessment on admission suitability. Poor communication and information contribute significantly to delayed and inappropriate discharge – against a backdrop of spare capacity across the care sector significantly outstripping the care needs of elderly patients stuck in hospital when they are medically fit to leave.

As well as having serious consequences for the health outcomes of elderly patients, delayed hospital discharges cost the NHS in the region of £4.8 million a day – and negatively impact other patients who cannot access the health services they need.

The systemic failures persist in all regions, despite NHS England identifying 'speed up discharge from hospitals' as one of its five key priorities in its *Delivery plan for recovering urgent and emergency care services, January 2023* – and despite the pledge by the former Conservative government of up to £250 million for the NHS to buy thousands of extra beds in care homes and other settings to help discharge more patients to free up hospital beds (January 2023)[1].

The social care sector has the capacity, the ability and the desire to be part of the solution. Moreover, speeding up hospital discharge will help the commercial viability of providers who face increasingly squeezed margins; 518 care homes closed in 2023, with a loss of 14,169 beds.

As our population continues to age, we need to ensure we have a robust care sector to meet its needs. Improving the hospital discharge process is a win-win-win-win-win: for elderly patients, the NHS, other patients trying to access health services, local authorities and the care sector.

Our report reveals some of the key challenges, outlines what needs to be done and proposes a solution.

More than 15 million people are projected to be over the pensionable age by 2045, with the number of those aged 85 and over expected to increase by one million to 2.6 million over the same period. Continuing to fail to find a solution to speedy, efficient and appropriate hospital discharges is unsustainable – for the NHS, for local authorities, for the tax payer, and – most importantly – for our elderly.

We challenge the government, health and social care leaders to think imaginatively to rise to the challenge.

Debbie Harris, Managing Director, Autumna

Foreword: Care England

Hospital discharge is a critical step in a person's journey towards recovery, but it can often be a complex and challenging process fraught with problems. What is sad is that some of these challenges are rooted in how the system works, particularly in how the NHS engages with social care.

This report clearly outlines that there is a significant problem with discharge and too much variance in the system's performance. Care providers are frustrated and angry by the lack of a clear and strategic approach to discharge, and the fact that nobody is delivering a national perspective.

We are constantly hearing about bottlenecks within hospitals, the root cause of which is often a lack of a clear and strategic approach to appropriately discharge patients. This pressure on the NHS is often self-made and is a symptom of a system that is obsessed with organisations and processes and has forgotten that people and outcomes should be the priority.

Care providers stand ready to develop a long-term and strategic approach to discharge, which could transform the experience of people who need support and significantly reduce the pressures on the NHS. The data in this report also shows that there is capacity in the system, and hospitals could relieve their pressures if they had a long-term and systematic approach to working with the care sector.

When the Integrated Care Systems (ICSs) were formed, we were told that this would be the route map to integration across health and social care, and yet, there are very few examples of a significant change in the way in which the system is functioning. In some areas, the arrival of ICSs in Integrated Care Boards (ICBs) has been negative, and they have undermined existing relationships and de-commissioned good rehab services. One of the major issues is that social care is not properly included in the structure of the ICB, and this has led to a lack of knowledge and understanding about the art of the possible. The contribution of social care can improve both outcomes and efficiency.

Autumna's *Hospital Discharge Report* should be a wake-up call for every part of the system because we have significant problems with discharge and these problems will only get worse. The demographic data on an ageing population should drive a radical and different approach to prioritising discharge and how the NHS works with other partners.

Autumna's *Hospital Discharge Report* clearly outlines a system that is failing and will only get worse unless remedial action is taken. However, this report also highlights the fact that there are solutions, and if people worked effectively with the social care sector and gave it the needed resources, the solutions would be easily and readily available.

I hope that everybody in the current system will read this report, see the issues graphically outlined, and commit to working collaboratively to solve these problems.

The current approach to discharge from the NHS at both local and national levels is a testament to repeated failure, and we owe it to citizens and the people who work so hard to deliver high-quality care to break this repeating pattern. If the system works collaboratively and gets everybody involved in identifying the challenges and what they can do to deliver the solutions, we stand a fighting chance of having a much more effective and efficient system that works better for the people who need it.

Professor Martin Green OBE, Chief Executive, Care England

> *"The people we speak to have **often not even seen the resident** and are **not aware of their medical needs** and often give incorrect information. I cannot trust the information given by the discharge team. **We have had many failed discharges where the residents coming back to us are not fit for discharge** and definitely not as per the information given by the discharge team. Mainly we get the impression that **the hospital want to discharge as quickly as possible** regardless of the needs of the patient and the service they are being discharged to being able to meet those needs."*
>
> Care Home, South East England

Contents

Why it matters

With an ever-ageing population, it is increasingly important for the NHS and social care services to work together to minimise the amount of time older people stay in hospital, both to improve outcomes for patients and reduce strain and cost on the NHS and the social care system.

This in turn will increase occupancy levels for care providers – importantly helping to improve their commercial viability in an increasingly complex and challenging landscape – to ensure we have sufficient provision to meet the care needs of our ageing population.

1.7 million the number of people aged 85 and over in mid-2020, making up 2.5% of the population[2]

2.6 million the number of people projected to be 85 and over by 2045, representing 3.5% of the total population[2]

15.2 million the number of people projected to be over the pensionable age of 67 by 2045, an increase of 28% on the mid-2020 level[3]

66% the proportion of **emergency admissions** to hospital accounted for by **people aged 80 and over**[4]

40% the **increase** in **emergency admissions** to hospital accounted for by **people aged 80** and over in 2021-22 compared with 2012-13[4]

The impact on patients delayed in hospital

Unnecessary stays in hospital result in worse health outcomes for patients[5]. This is even more acute in older patients (those aged 65 and over), who can quickly lose mobility and the ability to do every-day tasks[5]. Delayed discharge also being found to be associated with mortality, infections, depression, reductions in patients' mobility and their daily activities[6].

85% the estimated proportion of patients **aged 65 and over** whose transfer of **care from hospital is delayed**[5]

14% **reduction** in **leg and hip muscle strength** from **10 days of bed rest** among healthy older adults[7]

12% of **patients over 70** who saw a **decline in their ability to undertake key daily activities** (bathing, dressing, eating, moving around and toileting) **between admission and discharge** from hospital, with the extent of decline increasing with age[9]

5% of **muscle strength** that older people **can lose per day** of treatment in a hospital bed[5]

12% **reduction** in **aerobic capacity** experienced by healthy older adults from **10 days of bed rest**[8]

574x the **infection rate** of the Methicillin-resistant Staphylococcus aureus (MRSA) **among men aged 85 years** and over between 2008 and 2012, **compared with those aged under 45** (301.4 compared with 0.5 per million population); a **similar pattern was observed for women**[10]

20k+ **more** than 20,000 patients each year are **being discharged** into care homes and community beds **without any rehab, re-ablement or recovery support**[11]

The impact on the NHS

Speeding up discharge from hospitals was identified as a key priority to improve waiting times and patient experience in NHS England's *Delivery plan for recovering urgent and emergency care services, January 2023*[12]. This is especially important as the likelihood of a patient being readmitted to hospital is influenced both by the support they receive while in hospital and when they are discharged[13] – as well as the suitability of the care they are discharged into – with one in six patients over the age of 75 being readmitted within 30 days of being discharged[4].

£395
The estimated cost to the NHS of one night's stay in hospital[14]

12,266
The number of patients remaining in hospital who no longer met the criteria to reside, 30 June 2024[15]

£4,845,070
The cost to the NHS of delayed hospital discharge on one day, 30 June 2024[16]

The impact on other patients needing to access health services

Failing to discharge patients speedily from hospital restricts access to medical services for other patients needing them, adversely affecting health experiences and outcomes.

72% of people were seen within four hours in A&E (compared to the national target of 95%) in 2023/4[17]

10% of people attending A&E waited more than 12 hours in total in April 2024[17]

150,000 the number of people who had to wait more than 12 hours for a hospital bed after the decision to admit in Q1 2024 – up from 150 in Q1 2014[17]

73% of nurses have to provide care to patients in a non-designated clinical area at least once a day[18]

90% of nurses say patient safety is being compromised by being cared for in a non-designated clinical area[18]

300 deaths per week associated with long A&E waits 2022-23[19]

The impact on social care

For people aged 65 and over, longer stays in hospital can increase their long-term care needs[5]. If they are unable to fund their care, this puts even greater pressure on the public social care system, with an associated increase in costs.

£23.69bn
Local authority expenditure on adult social care 2022-23[20]

15%
The increase in local authority expenditure on adult social care in real terms between 2015-16 and 2022-23[20]

The impact on care providers

Since the Covid-19 pandemic, care providers have been struggling with a lack of confidence, compounded by significant increases in costs over the past two years. In 2023, 79% of providers reported that local authority fee increases did not cover the higher costs from the National Living Wage, while energy costs alone rose by an average of 72%[21]. With shrinking profit margins, operating with spare capacity—which could help address delayed hospital discharges—is now threatening the commercial viability of many providers.

11.2% of beds in care homes that are vacant and admittable, March 2024[22]

51,739 total beds in care homes that are vacant and admittable, Feb 2023[23]

518 the decline in the number of care homes in England during 2023[24]

14,169 the total number of care home beds lost during 2023[24]

40% of care providers reported a deficit in 2023[21]

39% of care providers considered exiting the market altogether in 2023[21]

19% of care providers made staff redundancies during 2023[21]

18% of care providers offered care to fewer people during 2023[21]

43% of care providers closed a part of their organisation or handed back contracts during 2023[21]

SOURCES

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4 Age UK, The state of health and care of older people in England 2023, July 2023

5 National Audit Office, Discharging older patients from hospital, May 2016

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8 For example, N de Morton, J L Keating, K Jeffs, Exercise for acutely hospitalised older medical patients, Cochrane Database of Systematic Reviews, January 2007.

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12 Department of Health & Social Care, Delivery plan for recovering urgent and emergency care services, January 2023

13 British Medical Association, Hospital discharge: the patient carer and doctor perspective, January 2014

14 The King's Fund, The hidden problems of delayed discharges and their costs, March 2023

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16 Figure arrived by multiplying the King's Fund estimate of the cost to the NHS per bed per day of delayed hospital discharge [14] by the total number of patients in hospital who no longer met the criteria to reside [15]

17 The King's Fund, What's going on with A&E waiting times? July 2024

18 Royal College of Nursing, Corridor Care Survey Results, 2020

19 Royal College of Emergency Medicine, April 2024

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21 Hft and Care England, Sector Pulse Check: A snapshot of finances and the workforce in the adult social care sector in 2023, January 2024

22 Gov.uk, Adult social care in England, monthly statistics: March 2024

23 Office for National Statistics, Care homes and estimating the self-funding population, England: 2022-23 – total CQC registered beds in February 2023 = 461,958

24 Care Quality Commission data

National findings

Autumna's survey of care providers shows widespread dissatisfaction with the hospital discharge process, with poor communication, poor information and poor relationships characterising the experiences of care providers.

Key findings

93.1% of care providers would like to see government reform of the hospital discharge process

85.3% of respondents who say they have a positive relationship with their local hospital discharge teams still say they would like the process reformed

48.7% of care providers do not feel the hospital discharge teams understand the care they offer

45.5% of care providers say information provided by hospital discharge teams is not accurate

44.6% of care providers think the information provided by hospital discharge teams is insufficient to make an initial assessment on admission suitability

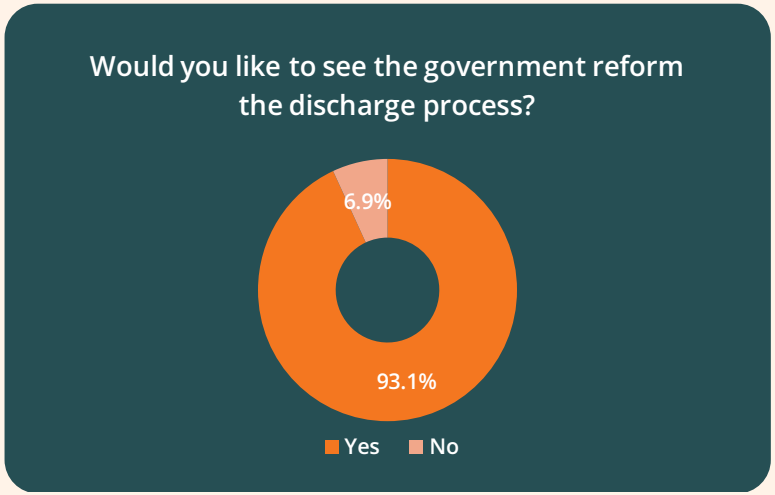
40.0% of respondents do not receive referrals from hospital discharge teams

34.0% of respondents who receive referrals from hospital discharge teams say they don't have a positive relationship with them

33.4% of respondents say they can't talk to discharge teams when they need to

17.0% of respondents say the average length of time for discharge into their care is one to two weeks

7.3% of respondents say the average length of time for discharge into their care is three or more weeks



*"**The information on discharge assessments is often wrong.** Twice in the past couple of months we have had residents discharged to us who have been actively dying on arrival, both died within two hours of arrival, neither family was prepared for this and we were not expecting it. **This has an impact on all of our staff and the time they have to care for other residents."***

Care Home, Yorkshire and The Humber

Top reasons for delays in patient transfer to care providers

1. **Funding not agreed** (203)
2. **Insufficient information** (181)
3. **Lack of communication** (151)
4. **Transport not agreed** (133)
5. **Waiting for care assessment** (108)
6. **Care needs changed** (104)
7. **Medication not agreed** (95)
8. **Waiting for support team to be in place** (77)
9. **Family disagree** (50)

Numbers in brackets denote the number of respondents who cited this as a reason for delays in the admission of patients to their care.

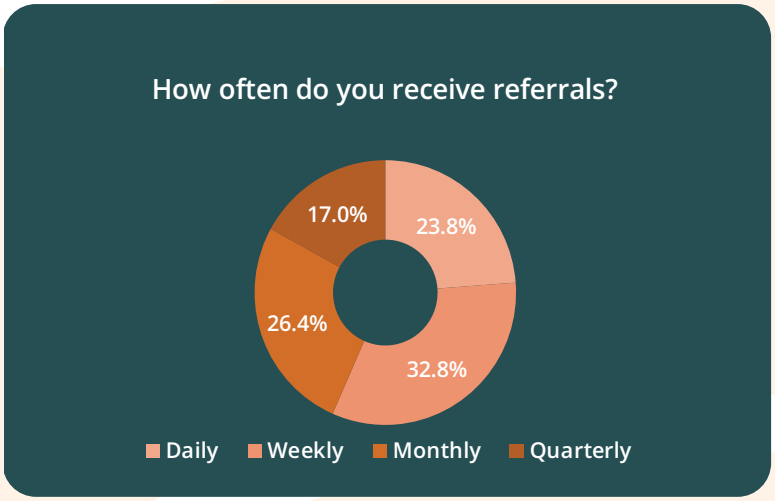
"It's just not collaborative and we don't work as a team and ***the poor customer is left in the middle of red tape."***

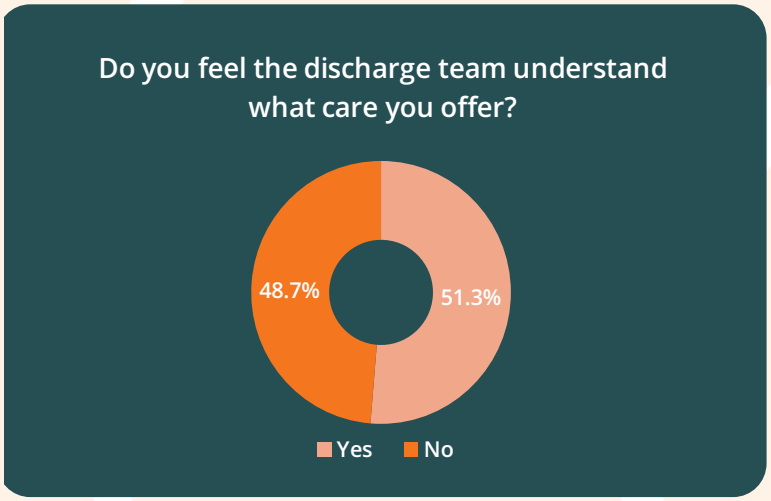
Home Care Provider, East Midlands

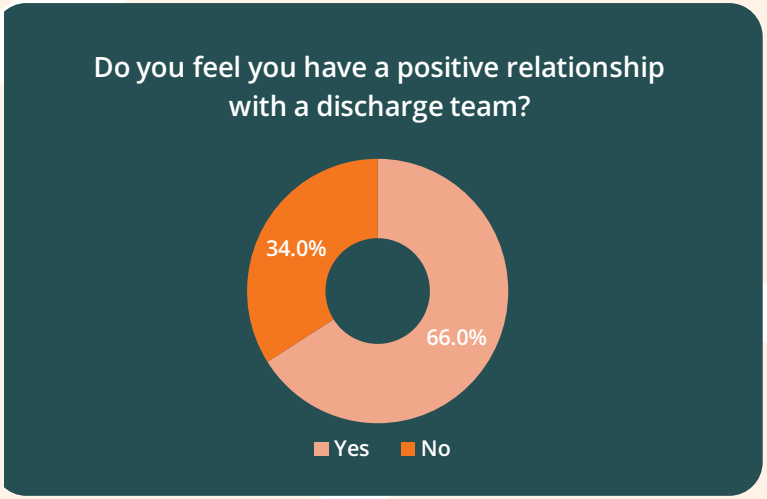
"Often patients are discharged without a discharge letter, no medication (insulin for example). ***Sometimes the discharge letters refer to another patient altogether and no one will take responsibility.*** *Sometimes discharge teams will downplay a patient's behaviours to ensure a quick discharge.* ***The whole system needs an overhaul."***

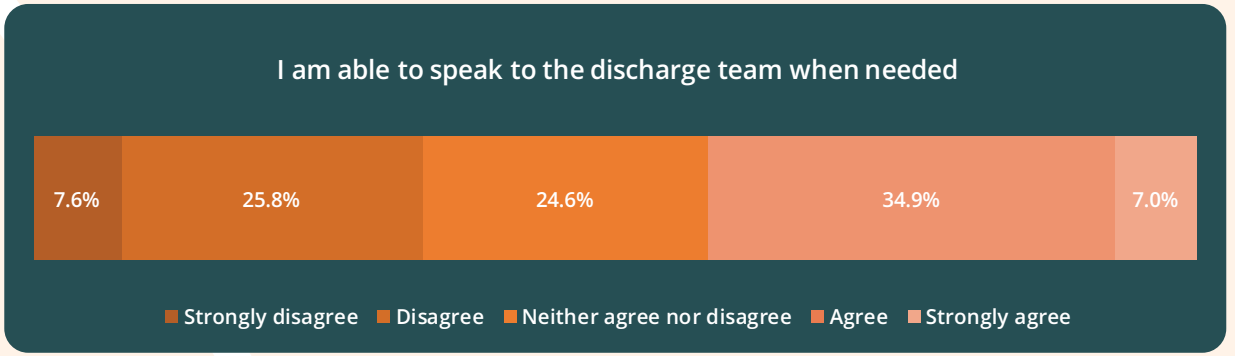
Care Home, East of England

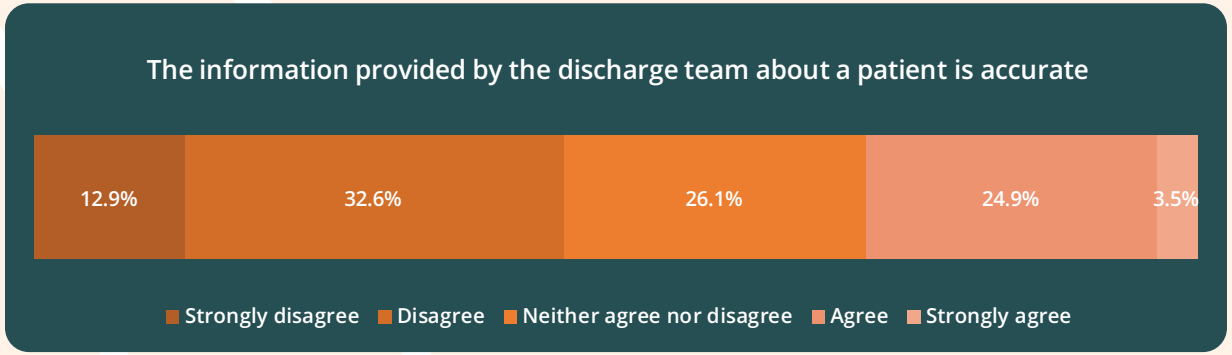

Does your organisation receive referrals from hospital discharge teams?
40.0%
60.0%
Yes
No

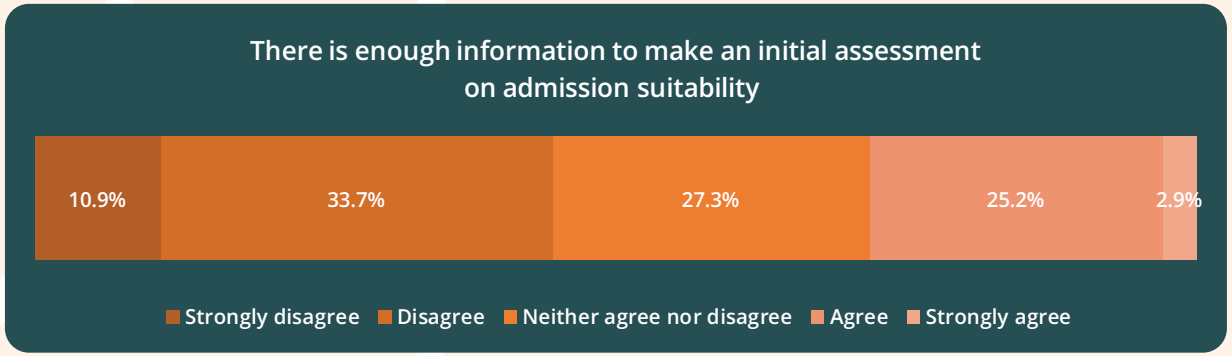

How often do you receive referrals?
17.0%
23.8%
26.4%
32.8%
Daily
Weekly
Monthly
Quarterly

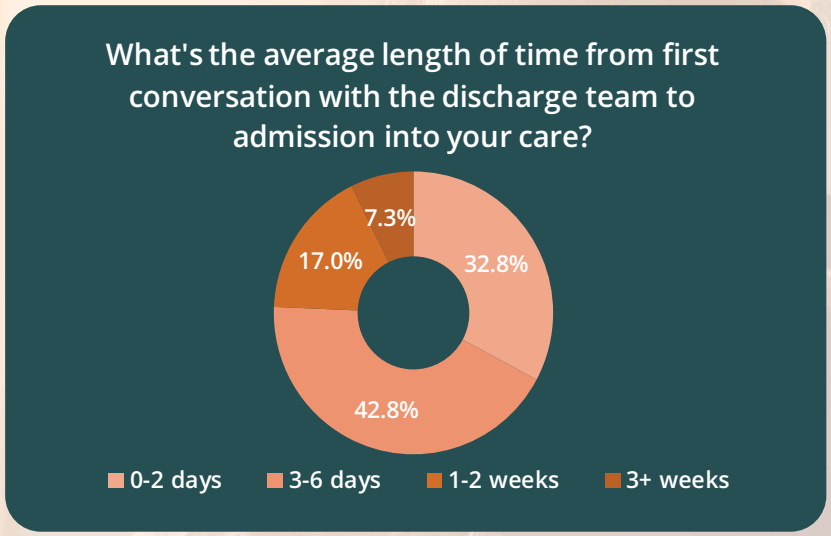

Do you feel the discharge team understand what care you offer?
48.7%
51.3%
Yes
No


Do you feel you have a positive relationship with a discharge team?
34.0%
66.0%
Yes
No


I am able to speak to the discharge team when needed
7.6%
25.8%
24.6%
34.9%
7.0%
Strongly disagree
Disagree
Neither agree nor disagree
Agree
Strongly agree


The information provided by the discharge team about a patient is accurate
12.9%
32.6%
26.1%
24.9%
3.5%
Strongly disagree
Disagree
Neither agree nor disagree
Agree
Strongly agree


There is enough information to make an initial assessment on admission suitability
10.9%
33.7%
27.3%
25.2%
2.9%
Strongly disagree
Disagree
Neither agree nor disagree
Agree
Strongly agree



Methodology

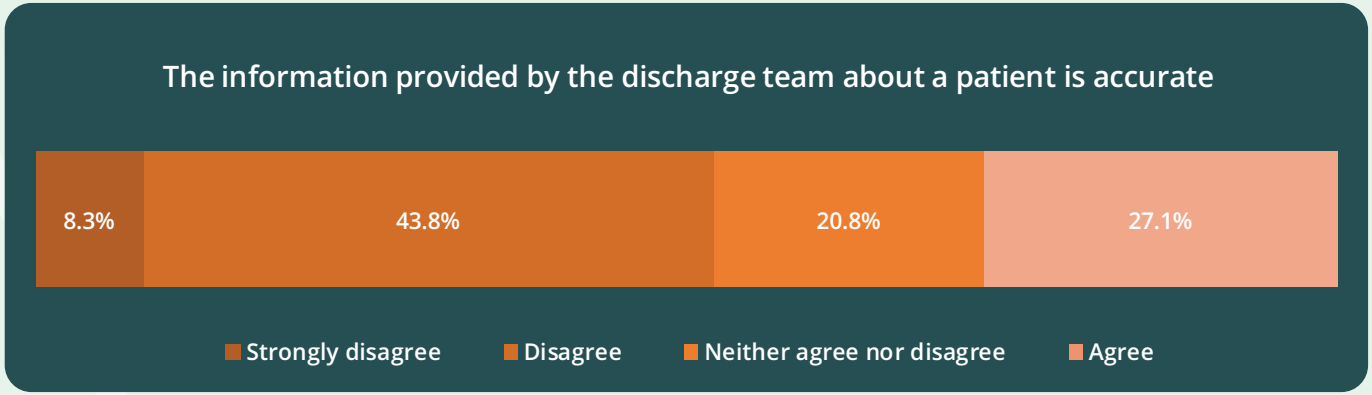
568 care providers (care homes and domiciliary care providers) across England, Wales, Scotland and Northern Ireland were questioned between 12 June 2024 and 18 July 2024 about their experiences of the hospital discharge process.

The findings are provided nationally and broken down into regions; the samples from Wales and Northern Ireland were too small to draw reliable regional findings.

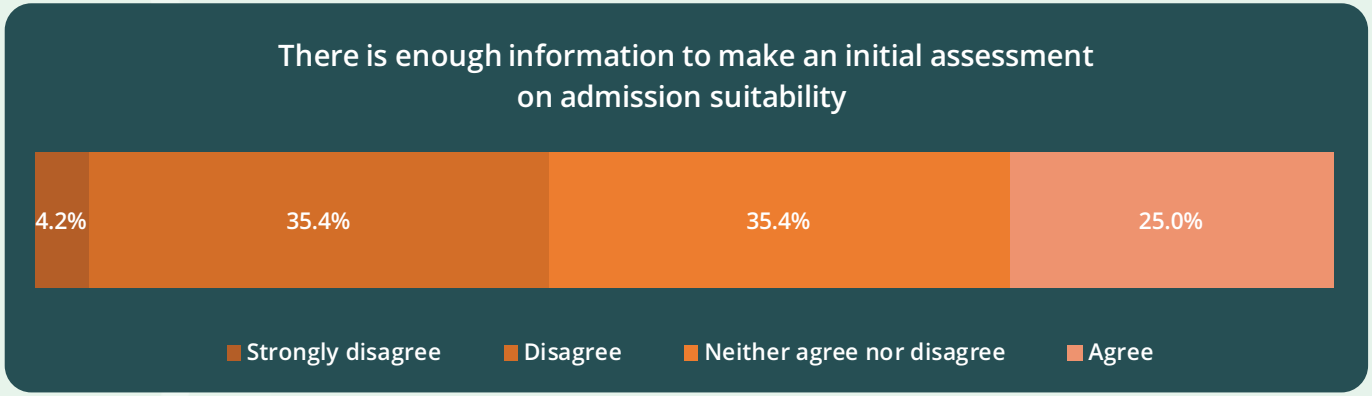
East of England

The East of England region shows a concerning landscape in discharge processes, with significant gaps in communication and information accuracy. However, these have failed to hinder speedy discharges, with the region outperforming everywhere else when it comes to transitioning elderly patients out of hospital and into care.

Communication is a key challenge. More than half of those surveyed (52.1%) said that they receive the wrong information from hospital discharge teams, which is higher than the national average of 45.5%.



31.3% of respondents say they cannot speak to the discharge team when needed, while 39.6% of respondents believe there is insufficient information to make an initial assessment on admission suitability.



*"I visited a few hospitals and they said **they can't help me unless I approach my council.**"*

Home Care Provider, East of England

36% of care providers in the East of England do not receive referrals from discharge teams. Of those who do receive referrals over a quarter (27.1%) said they have a poor relationship with hospital discharge teams. This potentially hints at a lack of collaboration and consistent working practices.

On a positive note, the region boasts the best performance in terms of timely admissions, with 95.8% of patients admitted within a week, far surpassing national averages. Just 4.2% said it took more than one week.

With the East of England excelling in minimising the time it takes for patient admissions into care, this suggests a strong capability to resolve information issues effectively to enhance the process for discharge teams, care providers and patients.

*"**Very poor process,** inaccurate discharge letters, no clear guidance on medication changes and transport issues. **Delayed physical discharge although patient on the system shows as being discharged from hospital.** However, they do not arrive in the care home until the next day, therefore for 24 hours they do not show as being in either facility."*

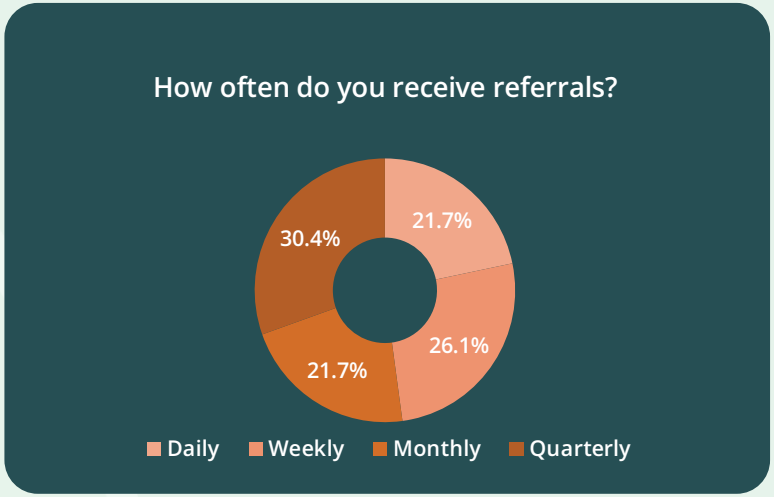
Care Home, East of England

		National	East of England
Number of responses		568	75
Don't receive referrals from hospital discharge teams		40.0%	36.0%
Would like to see the government reform the discharge process		93.1%	89.3%
Don't have a positive relationship with a discharge team		34.0%	27.1%
Don't feel the discharge team understand what care is offered		48.7%	45.8%
How often referrals are received	*Daily*	23.8%	20.8%
	Weekly	32.8%	37.5%
	Monthly	26.4%	25.0%
	Quarterly	17.0%	16.7%
Average length of time from first conversation with the discharge team to admission into their care	*0-2 days*	32.8%	35.4%
	3-6 days	42.8%	60.4%
	1-2 weeks	17.0%	2.1%
	3+ weeks	7.3%	2.1%
Able to speak to the discharge team when needed	*Strongly disagree*	7.6%	6.3%
	Disagree	25.8%	25.0%
	Neither agree nor disagree	24.6%	31.3%
	Agree	34.9%	33.3%
	Strongly agree	7.0%	4.2%
The information provided by the discharge team about a patient is accurate	*Strongly disagree*	12.9%	8.3%
	Disagree	32.6%	43.8%
	Neither agree nor disagree	26.1%	20.8%
	Agree	24.9%	27.1%
	Strongly agree	3.5%	0.0%
There is enough information to make an initial assessment on admission suitability	*Strongly disagree*	10.9%	4.2%
	Disagree	33.7%	35.4%
	Neither agree nor disagree	27.3%	35.4%
	Agree	25.2%	25.0%
	Strongly agree	2.9%	0.0%

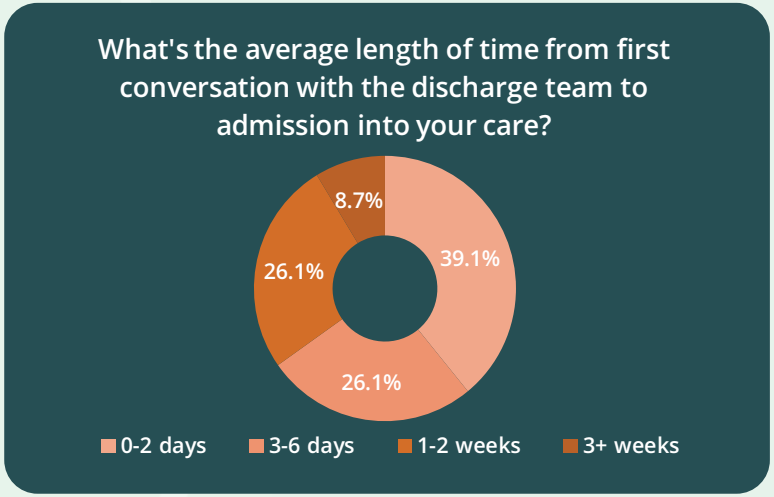
East Midlands

The East Midlands demonstrates a mixed performance in hospital discharge processes.

While some aspects of hospital discharge show promising results, significant challenges persist, impacting both providers and patients.



The data shows that there is a relatively high number of quarterly referrals (30.4% – nearly double the national average of 17%), compared to 21.7% of daily referrals. The lower daily referral rate may indicate that discharge teams are not contacting providers frequently enough. This could stem from inadequate processes for timely communication or inconsistencies in the referral system.



Our survey shows that 8.7% of care providers in the East Midlands stated that it takes at least three weeks to discharge a patient into their care, which is higher than the national average of 7.3%. A further 26.1% said it takes between one and two weeks, compared to the national average of 17%. If not addressed, these high levels of extended delays in hospital could potentially present a risk to patient health.

*"It is difficult when we go out and assess a resident and have agreed to accept admission; we then hold a bed, but **do not get updated when there is a change of need or funding and they no longer require the bed.**"*

Care Home, East Midlands

Encouragingly, only 13% of care providers said that they are unable to speak to the discharge teams when needed (compared to 33.4% nationally).

30.4% of respondents say the information provided by discharge teams is not accurate. However, this is still lower than the national average of 45.5%, which indicates that collaboration between providers and discharge teams could be enhanced if the consistency and accuracy of information sharing were improved.

"Many clients who have been with us for years are discharged to another cheaper option company and rebound into hospital. ***Many clients are not discharged as transport isn't available or medication hasn't been ordered."***

Home Care Provider, East Midlands

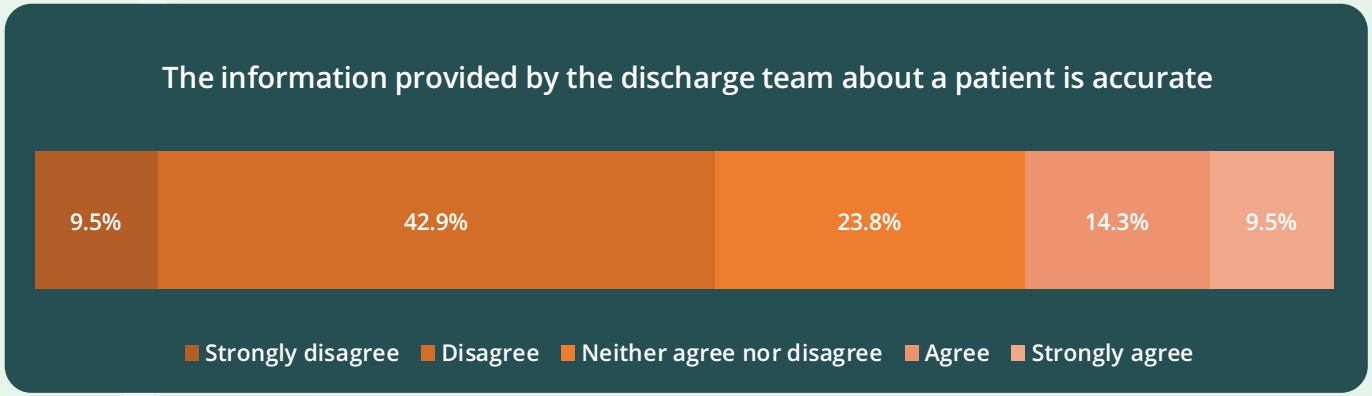
		National	East Midlands
Number of responses		568	39
Don't receive referrals from hospital discharge teams		40.0%	41.0%
Would like to see the government reform the discharge process		93.1%	92.3%
Don't have a positive relationship with a discharge team		34.0%	34.8%
Don't feel the discharge team understand what care is offered		48.7%	43.5%
How often referrals are received	*Daily*	23.8%	21.7%
	Weekly	32.8%	26.1%
	Monthly	26.4%	21.7%
	Quarterly	17.0%	30.4%
Average length of time from first conversation with the discharge team to admission into their care	*0-2 days*	32.8%	39.1%
	3-6 days	42.8%	26.1%
	1-2 weeks	17.0%	26.1%
	3+ weeks	7.3%	8.7%
Able to speak to the discharge team when needed	*Strongly disagree*	7.6%	0.0%
	Disagree	25.8%	13.0%
	Neither agree nor disagree	24.6%	43.5%
	Agree	34.9%	34.8%
	Strongly agree	7.0%	8.7%
The information provided by the discharge team about a patient is accurate	*Strongly disagree*	12.9%	8.7%
	Disagree	32.6%	21.7%
	Neither agree nor disagree	26.1%	39.1%
	Agree	24.9%	30.4%
	Strongly agree	3.5%	0.0%
There is enough information to make an initial assessment on admission suitability	*Strongly disagree*	10.9%	0.0%
	Disagree	33.7%	43.5%
	Neither agree nor disagree	27.3%	21.7%
	Agree	25.2%	34.8%
	Strongly agree	2.9%	0.0%

London

Our survey shows that there are gaps in communication and relationships between teams involved in discharging patients and care providers in London. Nearly half (47.5%) of care providers reported not receiving referrals from discharge teams, which is notably higher than the national average of 40%.

Even among those who do receive referrals, 23.8% indicated negative relationships with discharge teams.

There are widespread problems and inconsistencies with the way information is shared between providers and discharge teams, with 52.4% of providers saying that the information provided by the discharge team is not accurate.



*"**Reablement is not fit for purpose** for a number of clients which **increases their burden on the NHS**. Why not let clients that can afford to, top up or pay privately to work with private bespoke agencies that are strong at improving outcomes for more complicated cases."*

Care Home, London

However, despite these challenges, London's hospital discharge process was shown to be comparatively efficient, with 33.3% of care providers reporting that they receive referrals daily, compared to the national average of 23.8%.

Similarly, 42.9% of care providers said they get referrals weekly (national average 32.8%). This could either imply that better operational processes are in place or perhaps that care providers were already on an approved provider list.

Patient admissions into care facilities were also more efficient with no providers reporting that it took longer than three weeks, compared to 7.3% reporting this nationally.

However, in London, a wait time of one to two weeks appears to be common, with 19% citing this as an issue, compared to 17% nationally.

The relative efficiency with which hospital teams in London are discharging patients to care providers could be further enhanced by improving information sharing and widening the approved care providers list to create a more diverse pool of appropriate care options.

*"There **needs to be a complete overhaul of the whole process** to ensure that people are able to navigate between health and social care as effectively as possible, **reduce unsafe admissions and red tape** and ensure that we can work together more productively."*

Care Home, London

		National	London
Number of responses		568	40
Don't receive referrals from hospital discharge teams		40.0%	47.5%
Would like to see the government reform the discharge process		93.1%	92.5%
Don't have a positive relationship with a discharge team		34.0%	23.8%
Don't feel the discharge team understand what care is offered		48.7%	38.1%
How often referrals are received	*Daily*	23.8%	33.3%
	Weekly	32.8%	42.9%
	Monthly	26.4%	14.3%
	Quarterly	17.0%	9.5%
Average length of time from first conversation with the discharge team to admission into their care	*0-2 days*	32.8%	28.6%
	3-6 days	42.8%	52.4%
	1-2 weeks	17.0%	19.0%
	3+ weeks	7.3%	0.0%
Able to speak to the discharge team when needed	*Strongly disagree*	7.6%	0.0%
	Disagree	25.8%	23.8%
	Neither agree nor disagree	24.6%	23.8%
	Agree	34.9%	38.1%
	Strongly agree	7.0%	14.3%
The information provided by the discharge team about a patient is accurate	*Strongly disagree*	12.9%	9.5%
	Disagree	32.6%	42.9%
	Neither agree nor disagree	26.1%	23.8%
	Agree	24.9%	14.3%
	Strongly agree	3.5%	9.5%
There is enough information to make an initial assessment on admission suitability	*Strongly disagree*	10.9%	4.8%
	Disagree	33.7%	28.6%
	Neither agree nor disagree	27.3%	38.1%
	Agree	25.2%	19.0%
	Strongly agree	2.9%	9.5%

North East

The North East demonstrates notable strengths in the discharge process, outperforming national averages across multiple key metrics. However, there are still significant challenges associated with communication and gaining accurate information from discharge teams, resulting in calls for an overhaul of the discharge process.

Our survey shows that a third (33.3%) of providers said that they do not receive referrals from discharge teams. While this is lower than the national average of 40%, it is still high when compared to some other regions.

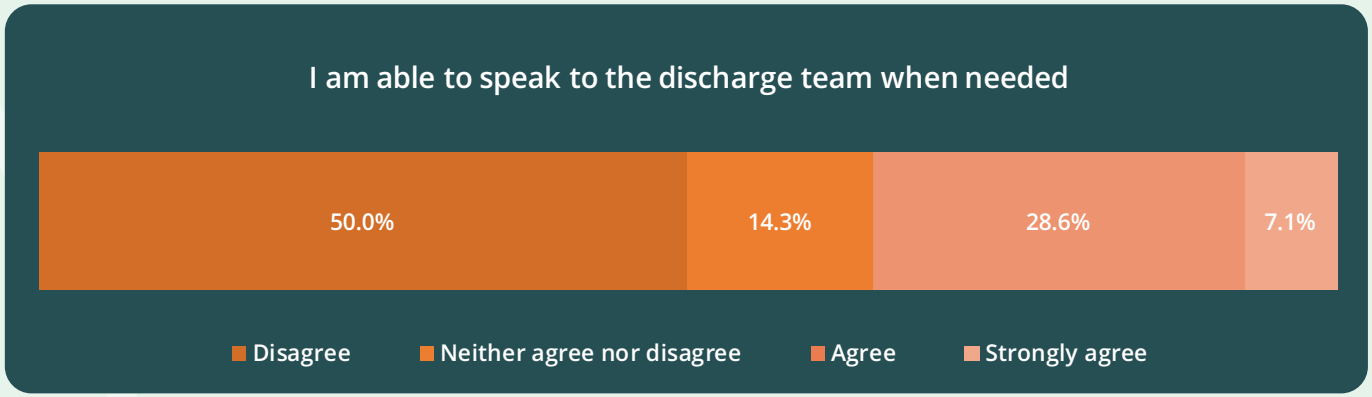
Encouragingly, no respondents said that the discharge process takes three weeks or more. While 14.3% said that the discharge process takes between one and two weeks, this is lower than the national average of 17%.

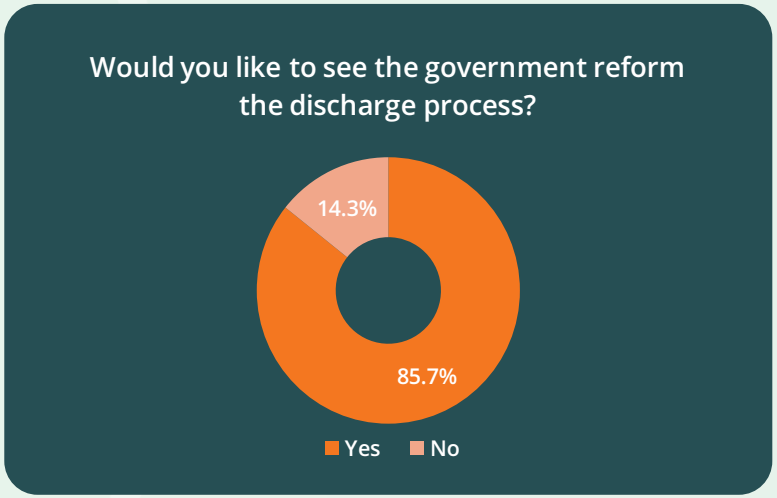
With half of respondents (50%) experiencing a discharge process of 0-2 days, the North East excels in minimising the time it takes for patients to be transferred to a care provider compared to other areas. This may indicate more efficient discharge practices in the region.

The majority of providers who do receive referrals have a good relationship with discharge teams, however nearly a quarter (21.4%) stated that this is an issue.

Getting accurate information from discharge teams is still a problem, with 50% of respondents stating that they cannot speak to the discharge team when needed, which is notably higher than the national average of 33.4%.

Similarly, 50% said the information provided by the discharge team is inaccurate, while the same number reported insufficient information to make an initial assessment of admission suitability. This is again higher than the national average.





Notably, despite a high proportion of referrals and relatively efficient processes with positive relationships, the vast majority of care providers in the North East (85.7%) have called for an overhaul of the discharge process.

*"**It is unfair how long** the potential resident has **to wait in the discharge unit** with no medication or diet/fluid intake and also the time of night the elderly are discharged... sometimes it has been around 10pm or later and it is not fair on them."*

Care Home, North East

Despite the North East's success in reducing the time it takes to admit patients into care compared to other regions, inconsistencies and breakdowns in information sharing continue to result in errors. These communication issues underline the need for a clear system that enhances all aspects of data exchange.

"The information that is given by the ward and discharge team does not always give the true reflection of the person who is needing care. ***There seems to be a lack of understanding between nursing needs and residential needs,*** *or lack of understanding that not all care providers have nursing."*

Care Home, North East

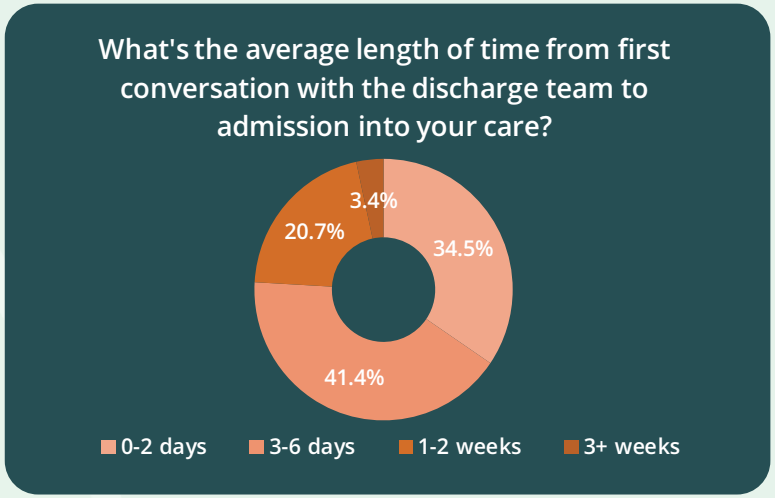
		National	North East
Number of responses		568	21
Don't receive referrals from hospital discharge teams		40.0%	33.3%
Would like to see the government reform the discharge process		93.1%	85.7%
Don't have a positive relationship with a discharge team		34.0%	21.4%
Don't feel the discharge team understand what care is offered		48.7%	50.0%
How often referrals are received	*Daily*	23.8%	21.4%
	Weekly	32.8%	42.9%
	Monthly	26.4%	28.6%
	Quarterly	17.0%	7.1%
Average length of time from first conversation with the discharge team to admission into their care	*0-2 days*	32.8%	50.0%
	3-6 days	42.8%	35.7%
	1-2 weeks	17.0%	14.3%
	3+ weeks	7.3%	0.0%
Able to speak to the discharge team when needed	*Strongly disagree*	7.6%	0.0%
	Disagree	25.8%	50.0%
	Neither agree nor disagree	24.6%	14.3%
	Agree	34.9%	28.6%
	Strongly agree	7.0%	7.1%
The information provided by the discharge team about a patient is accurate	*Strongly disagree*	12.9%	7.1%
	Disagree	32.6%	42.9%
	Neither agree nor disagree	26.1%	28.6%
	Agree	24.9%	21.4%
	Strongly agree	3.5%	0.0%
There is enough information to make an initial assessment on admission suitability	*Strongly disagree*	10.9%	0.0%
	Disagree	33.7%	50.0%
	Neither agree nor disagree	27.3%	28.6%
	Agree	25.2%	14.3%
	Strongly agree	2.9%	7.1%

North West

The North West region stands out as one of the strongest performers in the UK regarding hospital discharge processes. While challenges persist, several key areas highlight the region's strengths.

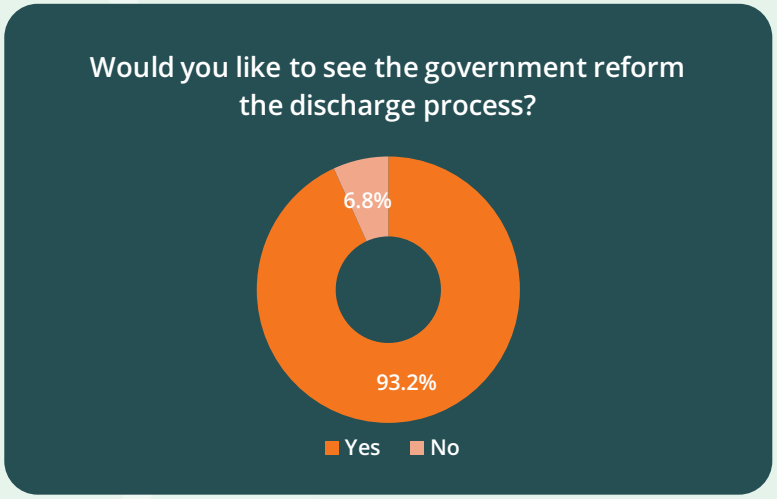
A notably low proportion of providers (20.7%) report negative relationships with discharge teams compared to 34% nationally, suggesting much better collaboration between hospitals and care providers.

This positive dynamic could potentially contribute to improved communication and information sharing.



However, the data also showed that nearly a quarter (24.1%) of providers said it takes over one week for a patient to be admitted into care – but this is still better than the national average.

The data also indicates other areas for improvement. A significant proportion of respondents (31%) feel the information provided by discharge teams is not accurate. While this is lower than the national average of 45.5%, this still highlights problems with the accuracy and detail of the information shared during the discharge process.



Similarly, 17.2% of care providers said they cannot speak to the discharge team when needed, compared to (33.4%) the national average.

The areas of dissatisfaction no doubt contribute to the fact that 93.2% of care providers in the North West want the government to reform the discharge process, even though the region outperforms other areas of the country on many metrics.

*"We often have times where **we are told a patient is mobile**, they come home and we go to provide care and **find they are, in fact, not mobile**."*

Home Care Provider, North West

While the North West shows some notable strengths, with a more efficient patient admissions process, there are areas where improvements could be made to communication between providers and hospital teams. Having said that, **the North West's overall performance in hospital discharge processes offers a valuable benchmark for other regions to emulate.**

By addressing the identified challenges and building upon existing strengths, the North West can solidify its position as a leader in this critical area of healthcare.

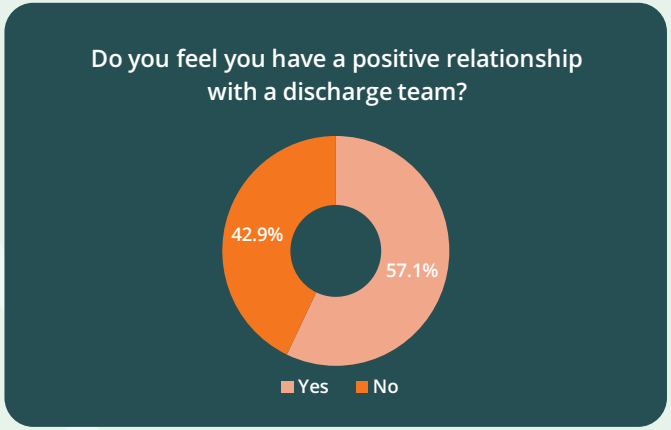
*"The discharge team get information from the wards and not always a true reflection of the potential client. **I feel the wards in the hospital will say anything for a client to be discharged** as we have had unsafe discharges in the past because of incorrect information regarding the needs of the clients."*

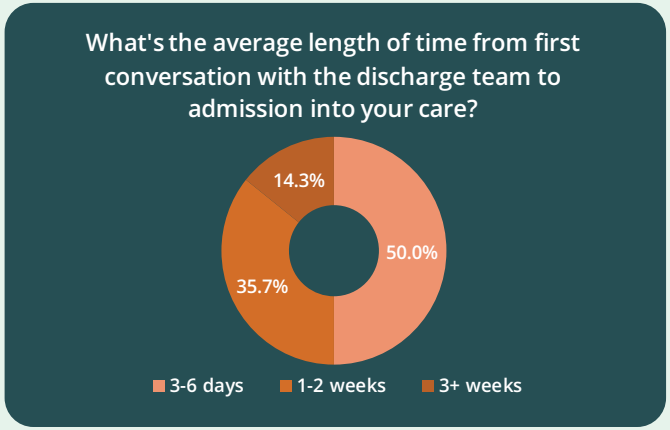
Care Home, North West

		National	North West
Number of responses		568	44
Don't receive referrals from hospital discharge teams		40.0%	34.1%
Would like to see the government reform the discharge process		93.1%	93.2%
Don't have a positive relationship with a discharge team		34.0%	20.7%
Don't feel the discharge team understand what care is offered		48.7%	34.5%
How often referrals are received	*Daily*	23.8%	31.0%
	Weekly	32.8%	44.8%
	Monthly	26.4%	13.8%
	Quarterly	17.0%	10.3%
Average length of time from first conversation with the discharge team to admission into their care	*0-2 days*	32.8%	34.5%
	3-6 days	42.8%	41.4%
	1-2 weeks	17.0%	20.7%
	3+ weeks	7.3%	3.4%
Able to speak to the discharge team when needed	*Strongly disagree*	7.6%	3.5%
	Disagree	25.8%	13.8%
	Neither agree nor disagree	24.6%	24.1%
	Agree	34.9%	51.7%
	Strongly agree	7.0%	6.9%
The information provided by the discharge team about a patient is accurate	*Strongly disagree*	12.9%	6.9%
	Disagree	32.6%	24.1%
	Neither agree nor disagree	26.1%	34.5%
	Agree	24.9%	31.0%
	Strongly agree	3.5%	3.5%
There is enough information to make an initial assessment on admission suitability	*Strongly disagree*	10.9%	10.3%
	Disagree	33.7%	34.5%
	Neither agree nor disagree	27.3%	24.1%
	Agree	25.2%	31.0%
	Strongly agree	2.9%	0.0%

Scotland

The discharge process in Scotland is under heavy scrutiny, with 100% of care providers advocating for government reform. This unanimity reflects the region being one of the worst performing in the UK.





This is caused by a lack of collaboration and strained relationships between providers and discharge teams, with 42.9% saying they don't have a positive relationship with discharge teams (which is higher than the national average of 34%). This suggests that the current system is not fit for purpose, because even among providers who do have a good relationship with discharge teams, 100% still want reform.

There is also widespread misunderstanding of the services care providers cover, with the majority (57.1%) stating that discharge teams do not understand what care they offer.

A notable concern is the disproportionately high number of infrequent referrals. 42.9% of care providers receive referrals only monthly, and a further 35.7% receive referrals only quarterly. By contrast, just 14.3% receive daily referrals and 7.1% receive weekly referrals. This inconsistency in contact frequency suggests potential issues within the referral process.

Patient admission is also a major problem in Scotland, with 50% saying that discharge times took more than a week. This highlights potential inefficiencies in the process, potentially compromising patient health by delaying their transition to appropriate care facilities.

*"Not always the fault of discharge teams. Lack of understanding from ward staff and as **they are under pressure to empty beds, information is not given correctly.**"*

Care Home, Scotland

These problems are compounded by a lack of accurate data, with 71.4% of care providers claiming they receive inaccurate information from discharge teams – much higher than the national average of 45.5%. Furthermore, nearly two-thirds (64.3%) said they do not receive enough information to assess patient suitability. This may potentially jeopardise patient well-being by prolonging the transition to the right care environment, or even meaning patients are discharged into the care of a provider who cannot meet their needs.

The widespread dissatisfaction with discharge processes, coupled with infrequent referrals and longer discharge times, position Scotland as one of the worst performing regions in the UK.

"Sadly this is one of many examples where ***Social Care and the NHS are not integrated*** *and therefore we are not able to work efficiently."*

Home Care Provider, Scotland

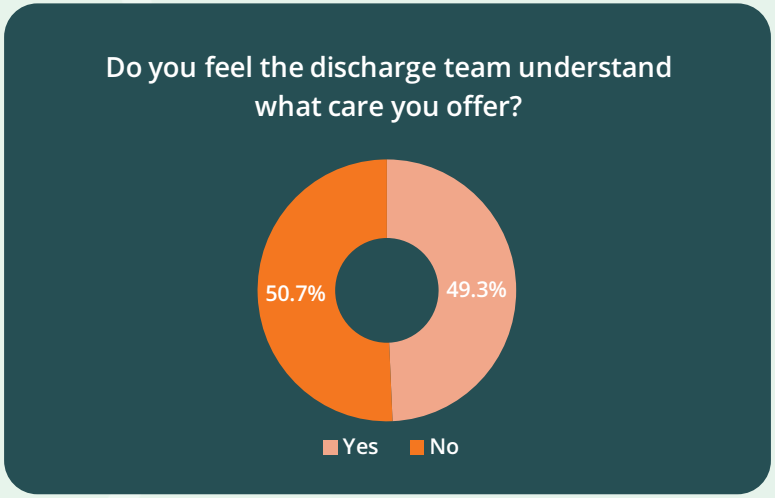
		National	Scotland
Number of responses		568	19
Don't receive referrals from hospital discharge teams		40.0%	26.3%
Would like to see the government reform the discharge process		93.1%	100.0%
Don't have a positive relationship with a discharge team		34.0%	42.9%
Don't feel the discharge team understand what care is offered		48.7%	57.1%
How often referrals are received	*Daily*	23.8%	14.3%
	Weekly	32.8%	7.1%
	Monthly	26.4%	42.9%
	Quarterly	17.0%	35.7%
Average length of time from first conversation with the discharge team to admission into their care	*0-2 days*	32.8%	0.0%
	3-6 days	42.8%	50.0%
	1-2 weeks	17.0%	35.7%
	3+ weeks	7.3%	14.3%
Able to speak to the discharge team when needed	*Strongly disagree*	7.6%	7.1%
	Disagree	25.8%	28.6%
	Neither agree nor disagree	24.6%	35.7%
	Agree	34.9%	28.6%
	Strongly agree	7.0%	0.0%
The information provided by the discharge team about a patient is accurate	*Strongly disagree*	12.9%	7.1%
	Disagree	32.6%	64.3%
	Neither agree nor disagree	26.1%	14.3%
	Agree	24.9%	7.1%
	Strongly agree	3.5%	7.1%
There is enough information to make an initial assessment on admission suitability	*Strongly disagree*	10.9%	0.0%
	Disagree	33.7%	64.3%
	Neither agree nor disagree	27.3%	21.4%
	Agree	25.2%	14.3%
	Strongly agree	2.9%	0.0%

South East

Dissatisfaction with hospital discharge processes is notably strong among care providers in the South East, with the region displaying higher levels of discontent than the national averages on numerous measures.

A significant 96.8% of respondents from Kent, East Sussex, West Sussex, Surrey, Hampshire, Berkshire, Oxfordshire, and Buckinghamshire express a desire for government reform of the discharge process. This demand for top-down change is second only to Scotland.

This dissatisfaction may be driven by the fact that 46.8% of respondents do not receive referrals from discharge teams, compared to the national average of 40%, making the South East the second highest regional figure behind London. This suggests that discharge teams have a restricted pool of approved providers, which may limit the available options to place patients in appropriate care.



The situation is further exacerbated by poor relationships and perceptions of hospital discharge teams. Over half (50.7%) of respondents feel that discharge teams do not understand what care providers offer (national average: 48.7%), and 41.8% report being unable to speak to a discharge team when needed (national average: 33.4%).

"We find that one member of the team will tell us one thing and then another will tell us something completely different. ***We struggle to get accurate information and have had information mixed up with other patients on more than one occasion.*** *We receive minimal information on discharge summaries and sometimes no discharge summary at all."*

Care Home, South East

Frustration is also high among care providers who do receive referrals from hospital discharge teams. A significant 40.3% report not having a positive relationship with the discharge teams (national average: 34%), and nearly half (47.8%) state that the information provided by discharge teams is inaccurate (national average: 45.5%).

Poor communication and relationships between hospital discharge teams and care providers and the resulting high levels of dissatisfaction with the discharge process suggest there is plenty of scope to improve the system in the South East to ensure elderly patients are discharged speedily into appropriate care settings.

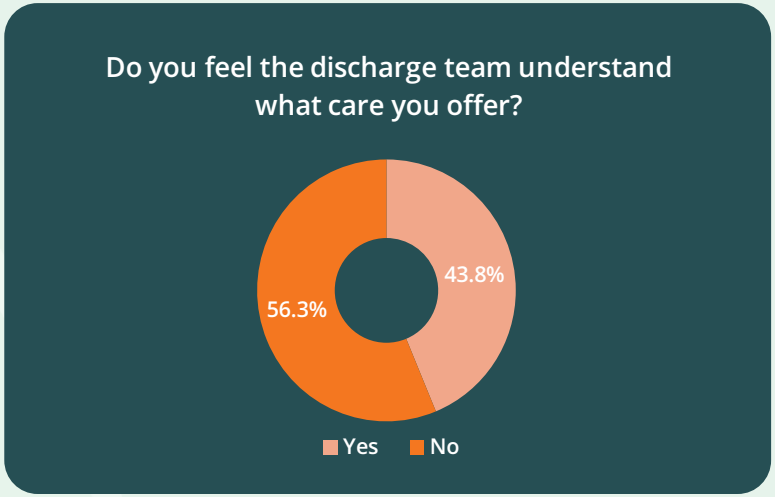
		National	South East
Number of responses		568	126
Don't receive referrals from hospital discharge teams		40.0%	46.8%
Would like to see the government reform the discharge process		93.1%	96.8%
Don't have a positive relationship with a discharge team		34.0%	40.3%
Don't feel the discharge team understand what care is offered		48.7%	50.7%
How often referrals are received	*Daily*	23.8%	11.9%
	Weekly	32.8%	32.8%
	Monthly	26.4%	28.4%
	Quarterly	17.0%	26.9%
Average length of time from first conversation with the discharge team to admission into their care	*0-2 days*	32.8%	35.8%
	3-6 days	42.8%	40.3%
	1-2 weeks	17.0%	17.9%
	3+ weeks	7.3%	6.0%
Able to speak to the discharge team when needed	*Strongly disagree*	7.6%	10.5%
	Disagree	25.8%	31.3%
	Neither agree nor disagree	24.6%	16.4%
	Agree	34.9%	34.3%
	Strongly agree	7.0%	7.5%
The information provided by the discharge team about a patient is accurate	*Strongly disagree*	12.9%	14.9%
	Disagree	32.6%	32.8%
	Neither agree nor disagree	26.1%	20.9%
	Agree	24.9%	26.9%
	Strongly agree	3.5%	4.5%
There is enough information to make an initial assessment on admission suitability	*Strongly disagree*	10.9%	17.9%
	Disagree	33.7%	25.4%
	Neither agree nor disagree	27.3%	28.4%
	Agree	25.2%	25.4%
	Strongly agree	2.9%	3.0%

*"**Reports of 300+ medically fit patients in our local hospital**, although the LA state they have no outstanding referrals and the NHS are stating there is no capacity in the community. **Discharge teams appear not to be asking the right people or widening their net.**"*

Home Care Provider, South East

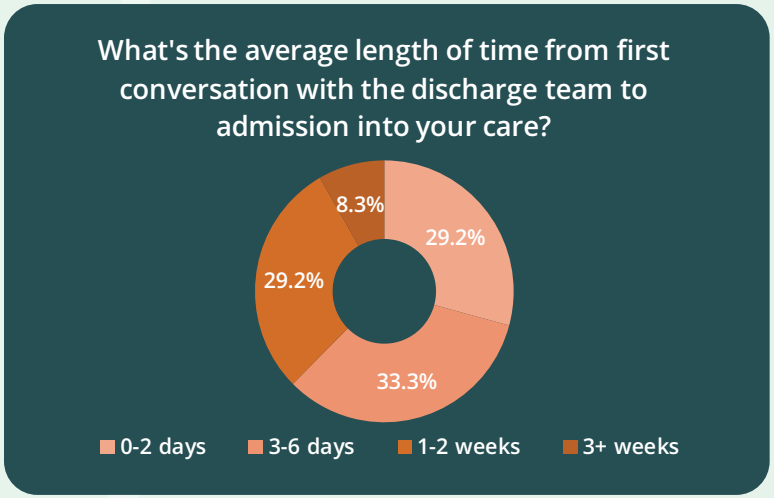
South West

There is a significant disconnect between care providers and discharge teams in the South West, highlighting a lack of knowledge about available services and patient needs.



Over half (56.3%) of care providers said that discharge teams do not understand what care they offer, which suggests that more training and education is needed for teams involved in discharging patients to care providers.

For those who do get referrals, 29.2% receive them daily, which is higher than the national average. While this does suggest good regular communication in some areas, only 8.3% get referrals quarterly, which is much less than the national average. However, the most pressing issue is the time taken for patients to be transferred after initial contact with the discharge team.



Despite frequent referrals, the South West experiences significantly longer wait times than the national average, with 8.3% of providers stating that it takes over three weeks to discharge a patient. A further 29.2% said that it takes between one and two weeks, compared to 17% nationally.

*"**The team do not get back to me when I am waiting for an answer** after I have offered a place. I have to chase and they might say 'Oh, this person went to a different home last week' or 'This person isn't fit for discharge' or 'We got a cheaper offer in another home'."*

Care Home, South West

A lack of effective communication between care providers and hospital teams contributes to these lengthy waiting times, with 35.4% stating that the information provided by the discharge team is not accurate. **Although this is lower than the national average (45.5%), it still highlights inherent problems within the discharge process, which suggests that information is not being shared accurately.**

"We have offered numerous times to support clients, including people we supported prior to hospitalisation, to discharge immediately, but have been declined because we are not on their contract framework. Instead, ***some clients have remained in hospital for over one week when medically fit, because contracted agencies haven't had capacity,*** *or won't cover areas because they are too remote. Our extra few pounds per hour compared to contracted agencies would still be far cheaper than the cost per bed in hospital, and would also allow other patients to be admitted to a ward from A&E."*

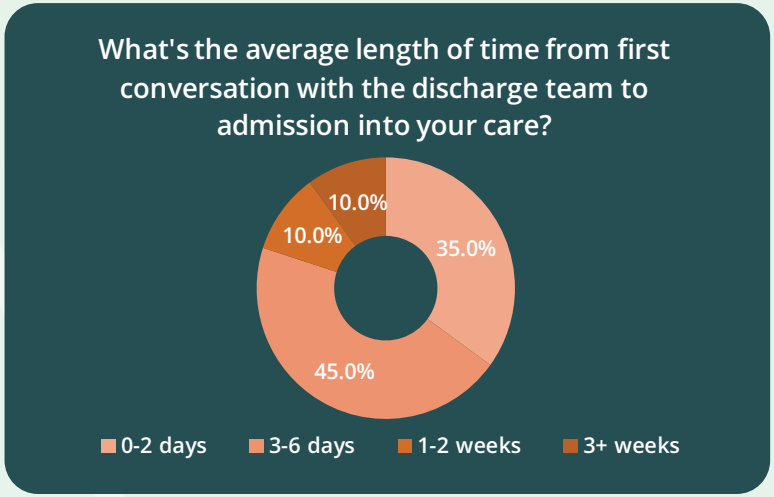
Home Care Provider, South West

		National	South West
Number of responses		568	81
Don't receive referrals from hospital discharge teams		40.0%	40.7%
Would like to see the government reform the discharge process		93.1%	91.4%
Don't have a positive relationship with a discharge team		34.0%	33.3%
Don't feel the discharge team understand what care is offered		48.7%	56.3%
How often referrals are received	*Daily*	23.8%	29.2%
	Weekly	32.8%	33.3%
	Monthly	26.4%	29.2%
	Quarterly	17.0%	8.3%
Average length of time from first conversation with the discharge team to admission into their care	*0-2 days*	32.8%	29.2%
	3-6 days	42.8%	33.3%
	1-2 weeks	17.0%	29.2%
	3+ weeks	7.3%	8.3%
Able to speak to the discharge team when needed	*Strongly disagree*	7.6%	10.4%
	Disagree	25.8%	18.8%
	Neither agree nor disagree	24.6%	31.3%
	Agree	34.9%	31.3%
	Strongly agree	7.0%	8.3%
The information provided by the discharge team about a patient is accurate	*Strongly disagree*	12.9%	8.3%
	Disagree	32.6%	27.1%
	Neither agree nor disagree	26.1%	27.1%
	Agree	24.9%	33.3%
	Strongly agree	3.5%	4.2%
There is enough information to make an initial assessment on admission suitability	*Strongly disagree*	10.9%	6.3%
	Disagree	33.7%	29.2%
	Neither agree nor disagree	27.3%	29.2%
	Agree	25.2%	31.3%
	Strongly agree	2.9%	4.2%

Yorkshire and the Humber

Despite a high proportion of care providers in Yorkshire and the Humber receiving referrals from discharge teams, there are strong calls for the process to be reformed.

Nearly nine in 10 respondents (89.3%) said they would like the government to reform the discharge process. Even among those who have a positive relationship with discharge teams, 78.6% said they still want reform, which highlights a widespread dissatisfaction with discharge processes in the region.



This could be influenced by the fact that 10% said it took over three weeks to discharge a patient. The lengthy discharge times could negatively impact patients' health.

However, the region performs better than others in the range of care providers getting regular hospital discharge referrals. Fewer than a third (28.6%) of care providers in Yorkshire report not receiving referrals from discharge teams, compared to 40% nationally.

"Discharges are usually delayed because medication isn't ready or transport didn't turn up. ***The information on discharge assessments is often wrong*** *because they are completed by non-medical staff who rely on the information given to them from the ward staff."*

Care Home, Yorkshire and the Humber

Of those providers that do receive referrals, 25% receive them daily, (compared to the national average of 23.8%), while 45% receive them weekly, compared to the national average of 32.8%.

While 30% of providers in Yorkshire and the Humber report difficulty speaking to discharge teams (compared to 33.4% nationally), the data still highlights the need for more consistent communication processes.

		National	Yorkshire and the Humber
Number of responses		568	28
Don't receive referrals from hospital discharge teams		40.0%	28.6%
Would like to see the government reform the discharge process		93.1%	89.3%
Don't have a positive relationship with a discharge team		34.0%	30.0%
Don't feel the discharge team understand what care is offered		48.7%	40.0%
How often referrals are received	*Daily*	23.8%	25.0%
	Weekly	32.8%	45.0%
	Monthly	26.4%	20.0%
	Quarterly	17.0%	10.0%
Average length of time from first conversation with the discharge team to admission into their care	*0-2 days*	32.8%	35.0%
	3-6 days	42.8%	45.0%
	1-2 weeks	17.0%	10.0%
	3+ weeks	7.3%	10.0%
Able to speak to the discharge team when needed	*Strongly disagree*	7.6%	0.0%
	Disagree	25.8%	30.0%
	Neither agree nor disagree	24.6%	25.0%
	Agree	34.9%	40.0%
	Strongly agree	7.0%	5.0%
The information provided by the discharge team about a patient is accurate	*Strongly disagree*	12.9%	5.0%
	Disagree	32.6%	35.0%
	Neither agree nor disagree	26.1%	25.0%
	Agree	24.9%	25.0%
	Strongly agree	3.5%	10.0%
There is enough information to make an initial assessment on admission suitability	*Strongly disagree*	10.9%	20.0%
	Disagree	33.7%	25.0%
	Neither agree nor disagree	27.3%	15.0%
	Agree	25.2%	35.0%
	Strongly agree	2.9%	5.0%

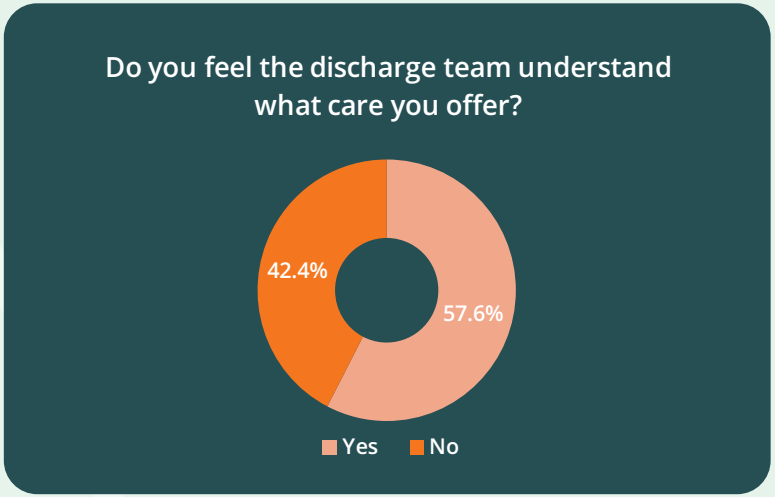
*"I think the discharge teams only work with **those whom they already know and do not consider new providers** in their area."*

Home Care Provider, Yorkshire and the Humber

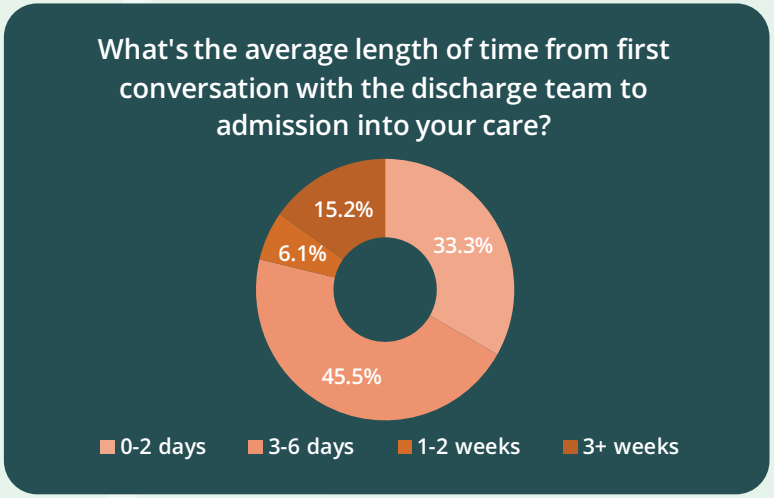
West Midlands

The West Midlands is one of the worst regions in the UK for collaboration between hospital discharge teams and care providers, indicating a severe breakdown in relationships and trust. This is underpinned by significant communications challenges, with the region facing substantial issues in information sharing.

More than half of providers (54.5%) said they don't have a positive relationship with a discharge team (compared to 34% on the national average).



There is also a significant knowledge gap in the discharge process, with 57.6% of respondents feeling that discharge teams do not understand the care they offer, and 54.5% of respondents finding the information that is provided inaccurate. This is significantly higher than the national average of 45.5%, indicating that misunderstandings and misinformation could severely hinder effective care planning and negatively impact patient outcomes.



Patient transfers are also a significant problem, with 15.2% of providers claiming that it takes over three weeks to get a patient admitted into their care.

This is exacerbated by communications delays, with half (51.5%) stating that they cannot speak to the discharge team when needed, compared to the national average of 33.4%.

"They generally lack any understanding of individual nursing homes abilities which all vary. ***The discharge teams do not provide good information to families about the process*** *which leads to frustration for them."*

Care Home, West Midlands

Providers also reported a higher percentage of daily referrals (33.3%) compared to the national average of 23.8%.
The disproportionately high rate of daily referrals may potentially hint at an over-reliance on a limited pool of providers with established relationships with hospitals.

This could potentially lead to capacity issues and limit patient access to a wider range of care options. Furthermore, it could perhaps suggest that providers not on these lists miss opportunities to offer solutions, creating an imbalance in care provision.

		National	West Midlands
Number of responses		568	54
Don't receive referrals from hospital discharge teams		40.0%	38.9%
Would like to see the government reform the discharge process		93.1%	92.6%
Don't have a positive relationship with a discharge team		34.0%	54.5%
Don't feel the discharge team understand what care is offered		48.7%	57.6%
How often referrals are received	*Daily*	23.8%	33.3%
	Weekly	32.8%	24.2%
	Monthly	26.4%	33.3%
	Quarterly	17.0%	9.1%
Average length of time from first conversation with the discharge team to admission into their care	*0-2 days*	32.8%	33.3%
	3-6 days	42.8%	45.5%
	1-2 weeks	17.0%	6.1%
	3+ weeks	7.3%	15.2%
Able to speak to the discharge team when needed	*Strongly disagree*	7.6%	21.2%
	Disagree	25.8%	30.3%
	Neither agree nor disagree	24.6%	12.1%
	Agree	34.9%	33.3%
	Strongly agree	7.0%	3.0%
The information provided by the discharge team about a patient is accurate	*Strongly disagree*	12.9%	33.3%
	Disagree	32.6%	21.2%
	Neither agree nor disagree	26.1%	24.2%
	Agree	24.9%	21.2%
	Strongly agree	3.5%	0.0%
There is enough information to make an initial assessment on admission suitability	*Strongly disagree*	10.9%	24.2%
	Disagree	33.7%	33.3%
	Neither agree nor disagree	27.3%	24.2%
	Agree	25.2%	18.2%
	Strongly agree	2.9%	0.0%

*"We have been working in our area now for 10 years. **The way the current hospital discharge works is not fit for purpose**, and the providers who are tied in contractually to work purely on discharge care packages are also not fit to operate from all the information and evidence we have seen, witnessed, and know of."*

Home Care Provider, West Midlands

Conclusion – what needs to be done

With 93% of care providers taking part in our survey saying they would like to see the government reform the hospital discharge process, there is strong evidence that the current system is not fit for purpose.

The disconnect across the UK between hospital discharge teams and care providers is costing the NHS and local authorities money, trust and reputation, and negatively impacting patients, leading to a decline in their health and often readmission to hospital.

This is not an issue of capacity; spare capacity in the care sector significantly outstrips the care needs of elderly patients waiting to be discharged from hospital.

The issue instead centres around identifying approved available care provision and communicating appropriate information to enable a clear and accountable hospital discharge.

The pressures are only going to increase as our population ages; therefore, solutions must be found.

Expanding approved care providers

Of the 40% of care providers who do not receive referrals from hospital discharge teams, nearly half are unsure why they do not – despite nearly all of them being open to hospital discharge referrals and many of them asking to become an approved supplier.

What needs to be done: Local authorities and hospital discharge teams need to widen their pool of approved care providers to give them more options to help facilitate the speedy discharge of elderly patients from hospital to available and appropriate care providers.

Poor communication and information

Poor communication and information dominate care providers' experiences of the hospital discharge process, leading to: patients being stuck in hospital; being discharged without the correct information, medication or even clothes; or being discharged to a care provider who is not able to meet their needs.

What needs to be done: Communication urgently needs to be improved – between hospital discharge teams and care providers, but also with medical staff and other parts of the jigsaw, such as transport teams – to ensure that elderly patients get the joined-up solutions and care they need to enable them to get out of hospital and stay out.

Funding disagreements

Funding not being agreed is the most common reason for delayed admission to a care provider. While the NHS and local authorities agree funding solutions, elderly patients are being kept in hospital, to the detriment of their health and at huge public cost.

What needs to be done: Consistent, easy-to-understand formulas are needed to enable intelligent funding decisions to be agreed swiftly to facilitate discharge to the right care provider.

Speeding up discharge from hospital was identified as a critical strategy by NHS England in January 2023 in the *Delivery plan for recovering urgent and emergency care services.* Autumna's *Hospital Discharge Report: Care Providers' Perspectives,* shows persistent shortcomings across the UK. Failing to take imaginative action to improve the system will continue to drain public resources and damage the health of elderly people.

The Solution

Autumna offers a pioneering solution for hospital discharge teams to speed up the discharge of patients into appropriate care: the Dashboard for Accelerated Discharge (DAD).

- ✓ ***Real-time care availability***
- ✓ ***Improve patient flow***
- ✓ ***Improve patient outcomes***

DAD
An integrated solution

The benefits of DAD for discharge and brokerage teams

Addressing the currently manual process of finding available care by the discharge teams, DAD creates a shortlist of pre-qualified, available care services in 60 minutes:

- **Reduces bed day delays and improves patient flow**
- **Reduces time spent by discharge teams on the phone by over 50%**
- **Frees more time to support patients**
- **Equivalent to having two extra members of staff in the discharge team**
- **Improves patient choice and outcomes**

Key features of DAD

- Independent – Autumna does not take referral fees from providers
- Full market search
- Ability to support all funding types across the UK
- Ability to support care home, home care and live-in care hospital discharge
- Easy to scale

How DAD works

1. Discharge team submit patient details
2. All appropriate care providers are contacted by email and text, filtered by location, care and funding
3. Dashboard populated by available, patient appropriate care providers within 60 minutes

Case study

The discharge team at Aneurin Bevan Hospital, South Wales had been trying unsuccessfully to find a care place for an elderly gentleman for eight months. DAD was recommended to them by a self-funding family.

40 minutes after entering the patient's details into DAD, several local providers confirmed they had availability and a placement was found.

"Autumna offers a new way of working which has the potential to assist patients, families and the NHS with its patient flow."

Gareth Lane, Senior Nurse, Aneurin Bevan Hospital, South Wales

Scan the QR code to book a no-obligation demo of DAD

Introductory offer:
36 months for the price of 30

DAD
An integrated solution

Autumna

About Autumna

Autumna is the UK's largest and most comprehensive later-life care directory. Specialising in supporting self-funders, it helps families and individuals make informed choices and identify services with the highest standards of care.

A leading voice and champion for self-funders, Autumna has the UK's largest and most detailed database of care providers, generating invaluable social care insight and statistics.

Proudly independent, Autumna offers impartial advice and does not accept referral fees or commission payments from care providers wishing to promote their services. Instead it aims to improve transparency and standards across the entire elder care sector.

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