

# Discharge from Hospital

Phase 1: Pre-Discharge

May 2026



# Contents

|  |    |
|--|----|
| Executive Summary .....                  | 2  |
| Introduction.....                        | 3  |
| Methodology .....                        | 5  |
| Findings.....                            | 7  |
| Context before discharge.....            | 7  |
| Information, support, and planning ..... | 9  |
| Readiness for discharge.....             | 11 |
| Overall experience .....                 | 12 |
| Next Steps .....                         | 14 |
| Appendix.....                            | 15 |

# Executive Summary

This report forms part of Healthwatch Cheshire's wider *Discharge from Hospital* project and focuses on the pre-discharge stage at Leighton Hospital. It explores patients' experiences of discharge planning while still in hospital, including how informed and supported people felt, and whether they were prepared to leave.

Between November 2025 and February 2026, **Healthwatch spoke to 20 Cheshire East residents** at the point where discharge was being discussed or finalised. Most patients had been admitted as emergencies, and lengths of stay varied from a few days to several months.

## What we found

Overall, patients were positive about the care they received on the wards, with **kindness and dedication of staff highlighted consistently**. However, some experiences of the discharge process itself were more varied.

**Most patients reported that they had been told about the discharge process and felt ready to leave hospital.** Family members and carers played an important role in supporting patients and helping them understand what would happen next. The majority of patients had also been seen by occupational therapists or physiotherapists as part of their preparation for discharge.

Despite this, some gaps were identified in how information and support were provided. **Written information was rarely given or clearly explained**, and some patients found it difficult to get answers to questions when they needed them. In several cases, **discharge arrangements were confirmed late or changed at short notice**, which affected people's ability to feel fully prepared.

While many patients felt ready to leave, this was sometimes based on a general understanding rather than detailed knowledge of what would happen after discharge. **Uncertainty around timings, care arrangements and practical support** remained for some.

This report highlights both the strengths of ward based care and the **importance of clear, timely communication and planning in supporting safe and confident discharge**. Findings from this stage will inform the next phase of the project, which will follow patients after leaving hospital to understand how discharge plans work in practice.

This is particularly relevant in the context of the NHS 10 Year Plan and the growing focus on neighbourhood health, where more care is delivered closer to home and within communities. Effective discharge planning, with clear communication and coordinated support, will be key to ensuring that neighbourhood-based services can meet people's needs safely and sustainably.

Findings from all phases will be published on Healthwatch Cheshire's websites, and shared with Mid-Cheshire NHS Trust, Cheshire East Local Authority, and Cheshire and Merseyside ICB.

# Introduction

## What is Healthwatch Cheshire

Healthwatch Cheshire East is the independent advocate for people who use health and social care services in Cheshire East. We listen to what local people tell us about their experiences and share those insights directly with the decision makers responsible for planning and delivering services. We are independent of the NHS or local authority. Our findings are published and shared directly with NHS trusts, local authorities and commissioners to inform how services are planned and delivered.

## Background

Healthwatch Cheshire is carrying out a wider *Discharge from Hospital* project to understand people's experiences of leaving hospital and the continued support they receive as part of the process.

The project aims to identify what is working well, where improvements may be needed, and how discharge can be better planned and delivered from a patient perspective. The project covers Leighton Hospital and the Countess of Chester hospitals with separate reports produced for Cheshire East and Cheshire West and Chester residents.

Effective discharge is a key priority across the NHS and local authorities and faces continued challenges. Ensuring people leave hospital at the right time, with the right support in place, is essential both for patient outcomes and for the wider health and care system.

While numbers of patients are known and are regularly reported on, the experiences of people are often not captured. Appendix 1 contains fuller notes taken during initial meetings, providing a richer snapshot of the patient experience.

Clear communication, coordinated planning, and involvement of patients and families are central to achieving a streamlined and effective discharge experience.

## Purpose of this report

This report focuses on the pre-discharge stage at Leighton Hospital and reflects the experiences of Cheshire East residents. It explores how discharge is communicated and planned while patients are still in hospital, including whether people feel informed, supported and prepared to leave.

As part of the wider project, patients are followed through different stages of their discharge journey. This allows Healthwatch to compare what was planned before discharge with what happens in practice once people leave hospital and begin their recovery at home or in another care setting.

This stage of the work looks specifically at patients' experiences prior to discharge. It includes:

- the context of admission and length of stay
- whether patients were informed about the discharge process
- where people were expected to go after leaving hospital
- the information, support and involvement they received
- whether they felt prepared and ready to leave

The findings provide insight into how discharge planning is experienced in practice at this stage and highlight areas of strength as well as opportunities for improvement. It also aims to identify examples of good practice that could be shared more widely.

Healthwatch would like to thank the Integrated Placement of Care Hub discharge team, who were responsible for compiling patient lists ahead of each visit. Communication was consistent throughout, and the team's efficiency made the visits possible.

Ward staff were equally supportive. They actively encouraged patients to share their experiences and were genuinely engaged with the purpose of the project. Staff knew their patients well and were always willing to provide information or updates about discharge plans – which helped patients feel informed and supported during the process.

# Methodology

## How Healthwatch carried out this work

This report forms part of Healthwatch Cheshire's wider *Discharge from Hospital* project. Healthwatch first met with Senior Mid Cheshire Trust staff to discuss the purpose of the project, the proposed approach, and how the work would fit with existing discharge arrangements. A Data Processing Agreement was then developed, agreed and signed so Healthwatch could access the limited patient information needed to carry out the wider discharge project safely and appropriately.

Healthwatch also met with relevant partners, including Trust discharge colleagues and local authority representatives, to understand local discharge pathways, review relevant policies and procedures, and refine the survey questions. This helped ensure that the questions were suitable for use in hospital and reflected the wider discharge process. The questions set were designed to support semi-structured conversations with patients, whilst still allowing people to describe their experiences in their own words.

**The day before each visit**, Healthwatch contacted designated staff within the Integrated Point of Contact for Hospital (IPOCH) team. At the end of the working day, IPOCH shared a list of patients planned for discharge the following day, along with their location in the hospital. Where recorded by the Trust, this included patients on discharge Pathways 0–3.

Pathway 0: home with no additional support;

Pathway 1: home with existing support;

Pathway 2: home with short-term support;

Pathway 3: bed-based care or rehabilitation.

This allowed Healthwatch to plan visits and identify patients who were at the point of discharge planning.

**On visit days**, Healthwatch staff attended Leighton Hospital and announced their arrival on the relevant wards and/or at the discharge lounge. Patients who had sufficient capacity to decide whether to take part were approached in person. Healthwatch staff introduced themselves, explained Healthwatch's independent role, and outlined the purpose of the project. Patients were told that the wider project would follow their discharge journey over time, from the point of leaving hospital through to home, a care home, or another care setting where appropriate.

Participation was voluntary. Patients could decline to take part or choose not to answer any question. Those who agreed to take part were asked to provide written consent. Section 1 of the survey was then completed with them whilst they were still in hospital. This allowed Healthwatch to capture people's views at the point when discharge arrangements were being discussed or finalised, rather than relying on people to remember these details later.

Healthwatch used the pre-discharge question set (Q1–Q24) which can be found in the appendix 2. These questions included:

- who we spoke to and where
- the context of the admission and length of stay
- whether they had been informed about discharge
- where they were expecting to go after leaving hospital
- whether they felt supported, informed and prepared
- who was involved in the discharge process
- any concerns they had before leaving hospital
- their overall views of the support and care they had received

Findings in this report are based on review of closed question responses alongside analysis of additional comments recorded during conversations with patients. Any examples used in reporting are anonymised.

This section reflects the experiences of people who were planned for discharge at the time of the visits, were available during visit times, and were able to give informed consent. It provides a snapshot of the pre-discharge experience across Healthwatch visits and offers direct insight into what patients were experiencing at the point they were preparing to leave hospital.

## **Who took part and where we spoke to people**

Healthwatch spoke to 20 Cheshire East residents at Leighton Hospital across 16 visit dates between 3 November 2025 and 17 February 2026.

Conversations took place in the discharge lounge and on hospital wards, depending on where patients were at the time of the visit. Although initial responses were collected from all 20 participants, one interview could not be completed in full because the patient's discharge transport had arrived. As further follow-up was not possible, this entry was closed, and the detailed findings in this section therefore draw on 19 completed responses. Context relating to this partial response has been incorporated where relevant.

Because this is the first section of a wider discharge project, the people included here were at different points in their hospital stay and had different discharge arrangements in place. Some were preparing to return home, whilst others were waiting to move to a care home or another care setting. Their responses, therefore, provide insight into a range of discharge circumstances, rather than a single patient group.

Conversations took place across Wards 1, 5, 7, 13, 14 and 27, as well as the Discharge Lounge, depending on where patients were at the time of the visit.

# Findings

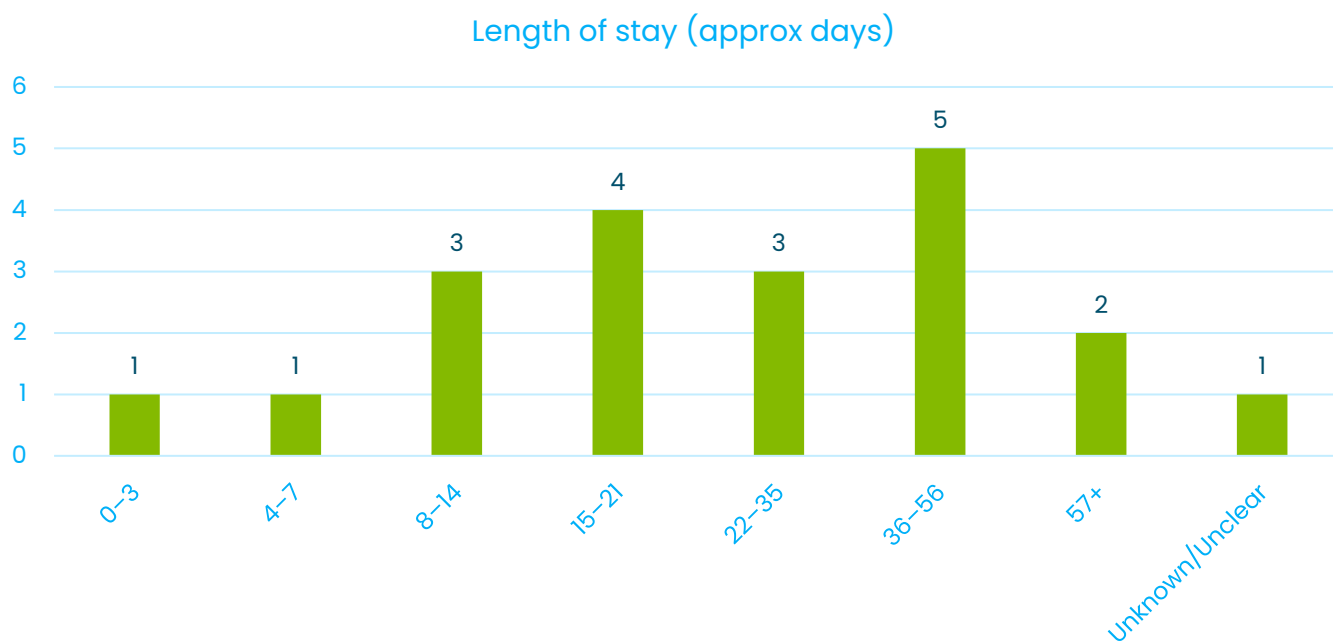
## Context before discharge

Patients' circumstances varied widely. People were admitted for different reasons, experienced a range of lengths of stay, and had differing expectations at the point of discharge.

### Admission and length of stay

15 out of 20 people described coming into hospital as an emergency or unplanned admission – including admissions by ambulance and ones that followed a routine appointment. Four described a planned admission, and one person was not sure.

Lengths of stay ranged from a few days to around nine weeks. Many patients had been in hospital for two to three weeks, while others had stayed for six weeks or more. For those with longer stays, being told they were going home could feel sudden, even when discharge had been planned over time.

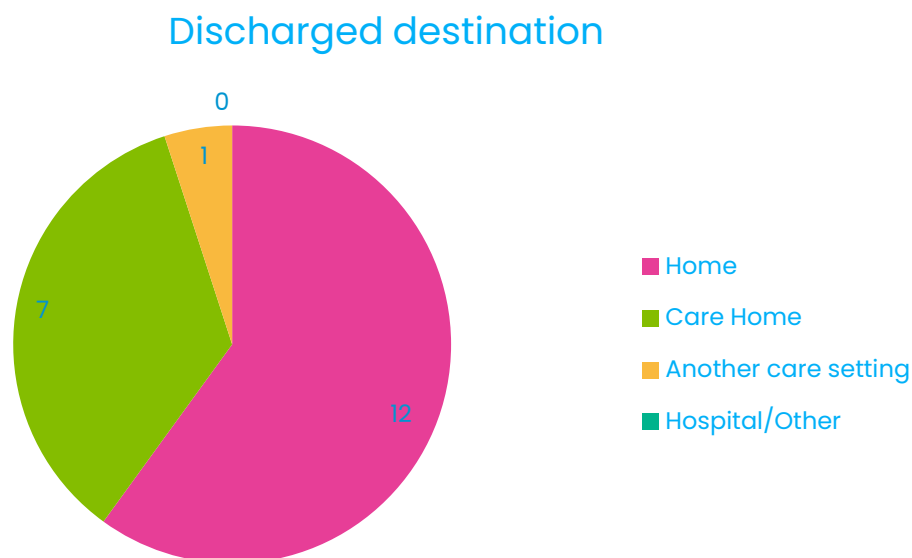


Of the four who came in as planned admissions, only one person said they had been told how long they would be in hospital.

### Discharge process and destination

18 out of 20 people said they had been told about the discharge process before leaving. For most, this came from ward staff, and it usually happened close to discharge – the day before, or one to two days beforehand. A few people said plans had changed over time before things were finalised.

12 out of 20 people were going home. Seven were going to a care home, and one to another care setting.



*At this point, one patient had been preparing for discharge for a week and reported that the process had been delayed due to the availability of hospital transport. When their transport arrived, the conversation could not continue, and no further questions were completed. The patient stated that they would be receiving support from carers at home, and Healthwatch arranged to follow up to schedule a home visit. However, further contact was not possible, and this survey entry was closed. As a result, the findings in the following section are based on 19 completed responses.*

### What patients told us: context

A patient admitted by ambulance after collapsing at home, said the uncertainty about when they would be discharged was the hardest part. The delay was linked to waiting for a specialist bed to be sourced and delivered to their home. They just wanted to be home.

One patient had been in hospital for nine weeks after being air-lifted following an emergency operation abroad. They expressed that the discharge process felt rushed and disjointed, with mixed messages and a sense that different parts of the team had not been talking to each other.

One patient was admitted unexpectedly following a routine eye appointment and spent six weeks in hospital. They described moving from ward to ward during that time, with limited explanation at each stage.

A patient came in via ambulance after a fall at their assisted living accommodation, badly breaking their foot. They said they thought they would only be there a few hours – they ended up staying about a week.

## Information, support, and planning

People's confidence in the discharge process depended on how clearly things were explained and how easy it was to get answers when they needed them.

### Staff support for questions

Just over half of people said a member of staff was available to answer their questions at each stage. Others said that was not always the case. Staff were busy and getting help at the point it was needed was not always straightforward.

When people could not get answers, some waited a long time after using the call bell. Others were told staff would come back – and then waited again. In some cases, family members ended up chasing information on the patient's behalf.

### Written information

18 out of 19 people said they had not been given written information about discharge. In two cases, written information was present but had not been pointed out – the patient only became aware of it during the Healthwatch visit.

Where written information was given, it was not always explained. One patient had a discharge letter but said they had not understood everything in it. Another said they could not read anything without their glasses, and no one had helped with that.

Mid Cheshire Trust's Integrated Discharge Team has it as a stated aim to produce written discharge information for patients, although this is not a national requirement.

### Support after discharge

15 out of 19 people said they knew about support planned after discharge. For most, this was a care package at home – carers visiting several times a day, and in some cases a follow-up GP visit.

Some people knew the broad outline but not the detail – who would provide the support, when it would start, or how long it would last. Some of those going to a care setting thought there would be rehabilitation but were not sure what that would involve.

### Did information meet needs?

14 out of 19 people felt the information they received met their needs. Five said it did not. For those people, timing was usually the issue.

As one patient put it, the information was there if you asked – but you had to know to ask.

## Who was involved

Discharge planning at this stage typically involves a mix of professional support and personal networks. Healthwatch asked about three groups who play a key role: social workers, occupational therapists and physiotherapists, and family or carers.

### **Social Worker**

Only 2 out of 19 people confirmed they had a social worker involved in their discharge. Some people were not sure whether they had one – there were often many different staff coming and going, and it was not always clear who did what.

### **Family/carers involved**

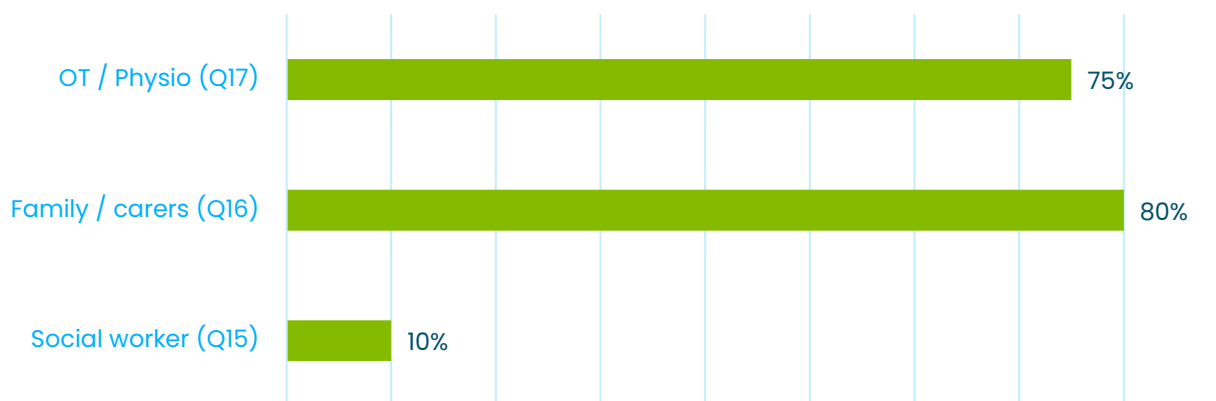
16 out of 19 people had family or carers involved. They spoke with staff, helped coordinate plans, and were often the main point of contact for updates. Three people did not have family or carers involved – in those cases, people were managing the process independently.

### **Occupational Therapist (OT) or Physiotherapist**

15 out of 19 people had seen an occupational therapist or physiotherapist during their stay. For some, this was brief contact. For others, it involved more regular sessions working on mobility, strength, and preparing to manage day-to-day tasks. Where OT was involved, it often included conversations about what equipment would be needed at home – beds, commodes, walking aids. Three people were not sure whether they had seen therapy staff. One said they had not.

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### Who was involved? – % Yes



## What patients told us: information and support

A patient who had been in hospital for six weeks described not having a member of staff she could consistently turn to with questions. Her family had stepped in to chase updates on her behalf, taking on a role that felt like it should have been managed by the team.

One patient told Healthwatch that the information had been sufficient on the whole, but reflected that they had needed to know what to ask in the first place. The discharge felt reactive rather than guided, and they would have found a more structured walkthrough helpful.

A patient described a care package not being arranged in time, meaning they were told on a Thursday to prepare for discharge, only to find they could not leave as planned. They described feeling disappointed and let down when the expected date came and went.

A patient described being seen by a social worker around a year before this admission following a previous hospital stay. At that point they had been temporarily housed in a hotel while a suitable property was found. They had no social worker this time and managed the discharge process themselves.

One patient said their sister, as next of kin, had been communicating directly with the hospital about their discharge and that this arrangement had worked well for them.

## Readiness for discharge

16 out of 19 people said they felt prepared to leave hospital. Three did not. Their concerns included whether adaptations would be in place at home, uncertainty about what carers would do, and for one person, not feeling physically well enough to leave.

## Concerns about discharge preparation

15 out of 19 people didn't raise significant concerns about how their discharge was being prepared. For most of them, the basics were in place – they knew where they were going and broadly what support had been arranged, although information gaps still existed, even for people who said they felt ready. For some, a care package was in place, but the details had not been confirmed – for example when care would start, who would be providing it, and whether anyone would be there when they arrived home.

Four people raised concerns. Those concerns fell into three areas: timing, planning, and what support would look like once they were home. Some felt discharge came with little warning after a long stay – there was not enough time to prepare mentally or practically. Others were uncertain whether the care arranged would actually work – equipment arriving without explanation, or care packages not confirmed in time. One person was distressed about going to a care home and felt they had no say in the decision.

## Were concerns dealt with appropriately?

For most people this question did not apply as they had no concerns to raise. Of the four who did, two said their concerns were not dealt with appropriately. In one case, they said the discharge felt rushed and disorganised, and staff themselves acknowledged that to be the case, but no changes were made. In the other case, a patient repeatedly told staff they did not feel well enough to leave. They were not sure whether anything happened as a result.

### What patients told us: readiness for discharge

One patient described feeling ready to go home but remained worried about whether a ramp would be in place when they arrived. It had not yet been confirmed.

A patient who had been in two hospitals for close to seven months described feeling overwhelmed at the news they were being discharged the following day. They said the notice was too short given how long they had been in hospital and how much was about to change.

One patient told Healthwatch they did not feel physically well enough to leave and had said so to staff. They were unsure what, if anything, had happened in response to that.

A patient being discharged to a care home described feeling that this was not something they could influence. Although they said they had seen the brochure and could see why the decision had been made, they would have preferred to go home.

A patient said they had not been told how long they would be in hospital before their planned admission. When discharge came, it felt sudden – they had not had time to prepare mentally or practically.

A patient's family said the build-up to discharge had gone ok and they were glad to have them coming home – but flagged that a leg strap for a catheter bag had been requested several times during the stay and never provided, which left them less confident about managing at home.

## Overall experience

### Communication about discharge date

18 out of 19 people said they were kept informed about their expected discharge date but this did not always mean the plan felt settled. Several people described dates moving or being pushed back, waiting for a specialist bed to be delivered at home, waiting for a care home to confirm a place, or delays linked to transport. Some people received a number of updates over a couple of days whilst others were told the day before, then again on the day. One patient said the 'only reason' she knew she was being discharged that afternoon was because she had asked.

## Transport

16 out of 20 people expected to travel by hospital transport or ambulance. Three expected to go by car or with a relative. One person was not sure.

For those relying on hospital transport, the timing was often uncertain. People knew transport was coming – but not when. That meant sitting and waiting without knowing if it would be an hour or much longer.

## Waiting to leave

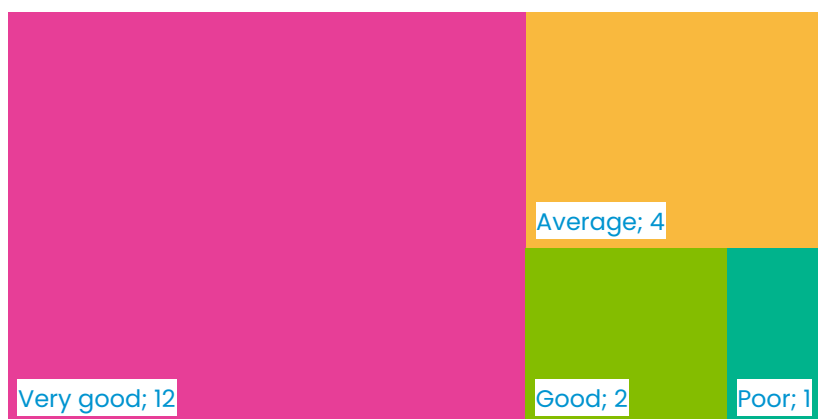
For many people, the experience of actually leaving hospital was shaped by what happened in the final hours, and for some overnight, before they went.

Several people described spending long periods in the discharge lounge, including overnight stays. By the time discharge came, some were exhausted. People mentioned poor sleep, noise, and feeling unwell while waiting. Some described being moved to the lounge before all the arrangements were in place – and then waiting there for the pieces to come together.

Timing caused frustration in other ways too. One person was woken very early on the day of discharge even though they were not leaving until the afternoon. Another was told different things by different staff about when their medication had arrived. Several people described a general sense of things not being joined up – different staff giving different information, with no clear single point of contact.

## Overall rating

12 people rated the support and care they received as very good. Two rated it good, four rated it average, and one rated it poor. One person did not give a rating. The rating question asked about support and care received at the hospital – not the discharge process specifically.



People who gave high ratings often still described difficult moments alongside them. A long and exhausting wait in the discharge lounge – watching nurses working under visible pressure, short-staffed and stretched. Several people reflected that it felt unfair to be critical of individual staff given the conditions they were working in. The most consistent positive theme across the comments was the relationships people built with ward staff. People described feeling genuinely known and cared for – staff who took time to talk, remembered

things about them, and made them feel looked after even when the system around them was under pressure.

This rating reflects people's experience of care up to the point of the visit. The next phase will follow the same patients after leaving hospital and will give a fuller picture once the full process is complete.

## **What patients told us: overall experience**

One patient described a seven-week stay and said it felt unfair to criticise the nursing staff, describing them as incredible. They reflected that a single negative interaction over that time was not a bad overall record – but they had made a complaint about it at the time.

A patient described being woken at 6am on the day of discharge, then sitting in a chair for around two hours before being offered a cup of tea. Discharge did not happen until the afternoon. They did not understand why they had been woken so early and found the long wait difficult.

One patient told Healthwatch that the care on the ward had felt very homely – staff reached out and made them feel at home, and the consultant had a visibly good relationship with the team. However, they noted that communication was not always straightforward when staff spoke with different accents or languages.

A patient in the discharge lounge described spending the night there and getting no sleep. Patients had been shouting and she described staff as a little impatient in the lounge. She arrived at the point of discharge feeling worn out.

One patient described their overall experience of care as very good, but flagged a short period on an intermediate ward as awful. Her son had collected a complaints leaflet but she had not felt ready to use it, and she said she would probably just put it behind her once she got home.

A patient described the experience of being in hospital as awful overall. She had spent 24 hours on a bed in a corridor after arriving by ambulance, and said she had felt unable to communicate properly with most staff throughout her stay. She rated the care as poor.

One patient said: 'Nothing wrong with the care, the staff work under lots of stresses.' They described a night on the ward where a nurse was left alone with 32 patients, visibly upset and overwhelmed. 'I could tell she was getting very upset. I saw her talking to a doctor – when they had gone she had tears in her eyes.'

One patient described being moved from ward to ward. Some nurses had been good and they felt listened to; others had lacked empathy. One nurse in particular on an evening shift had made them feel genuinely cared for and listened to.

A patient said the reason they rated care as very good was because of staff talking to them and getting to know them. That way, they said, you build a relationship and feel cared for.

## Service Provider Response

We welcome this report and thank patients and families for sharing their experiences. It is encouraging to see consistent recognition of the kindness and dedication of our staff, which reflects the care we strive to deliver every day.

The findings also highlight important areas for improvement, particularly around communication, timeliness of discharge planning and clarity about post-discharge support. While many patients felt ready to leave hospital, it is clear that not everyone felt fully informed or confident about what would happen next.

In response, we are committed to strengthening our approach to discharge by:

- Improving clear, consistent communication, including better use and explanation of written information
- Starting discharge planning earlier and reducing last-minute changes
- Working more closely with partners to improve coordination of post-discharge care
- Enhancing the day of discharge experience, including reducing delays and keeping patients informed

We recognise discharge is a whole-system process and will continue to work with partners to ensure a more seamless transition from hospital to home or another care setting.

Our priority is that every patient leaves hospital feeling safe, informed and supported, with a clear understanding of what happens next.

With thanks as always to Healthwatch for their work with our patients and communities.

- Scott Malton, Chief Nursing Officer, Mid Cheshire Hospitals NHS Foundation Trust.

## Next steps

The next stage of this project will follow the same patients through their transition from hospital – capturing what discharge actually looked like once they left, whether they returned home, moved to a care home, or another care setting.

Findings from all phases will be published on Healthwatch Cheshire's websites, and shared with Mid-Cheshire NHS Trust, Cheshire East Local Authority, and Cheshire and Merseyside ICB to help inform how discharge processes are planned, resourced and supported.

Together, the findings from all phases will give a fuller picture of the discharge journey from hospital to home. Recommendations based on the complete picture will be published alongside the final report.

# Appendix

**Appendix 1 – Interview Notes**

**Appendix 2 – Survey Questions**



# healthwatch

## Cheshire East

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