healthwatch
Milton Keynes

Milton Keynes Integrated Discharge Hub: Patient Experience Report

June 2026

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Executive Summary

Milton Keynes Integrated Discharge Hub – Patient Experience Report

Healthwatch Milton Keynes was commissioned by the Milton Keynes Health and Care Partnership, with support from the Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK ICB), to undertake an independent evaluation of patient experience of discharge through the Integrated Discharge Hub (IDH). This work took place over 18 months between September 2024 and March 2026, during a period of significant transformation across the local health and social care system.

The Integrated Discharge Hub is an ambitious model designed to address long standing challenges to 'system flow'. 'System flow' refers to how we, as patients, move smoothly and effectively through the health and care system. When system flow works well, each stage of our journey — from hospital care to discharge and ongoing support — happens in a timely, coordinated and predictable way. When system flow breaks down, patients experience duplication — such as repeated assessments, repeated questioning, and multiple professionals providing overlapping or conflicting information — alongside miscommunication, longer-than-necessary hospital stays, and fragmented decision-making.

These challenges have been repeatedly highlighted through system mapping, operational reviews, and years of Healthwatch insight. The Integrated Discharge Hub was established to respond to these issues by bringing together professionals from acute, community, social care, therapy, housing, pharmacy and voluntary sector services into a single, coordinated function. The IDH is supported by unified management and a single point of contact for patients and families.

This evaluation sets out the local health and care system's ambition to develop the IDH as a mechanism for improving system flow and examines to what extent patient experiences reflect those planned improvements.

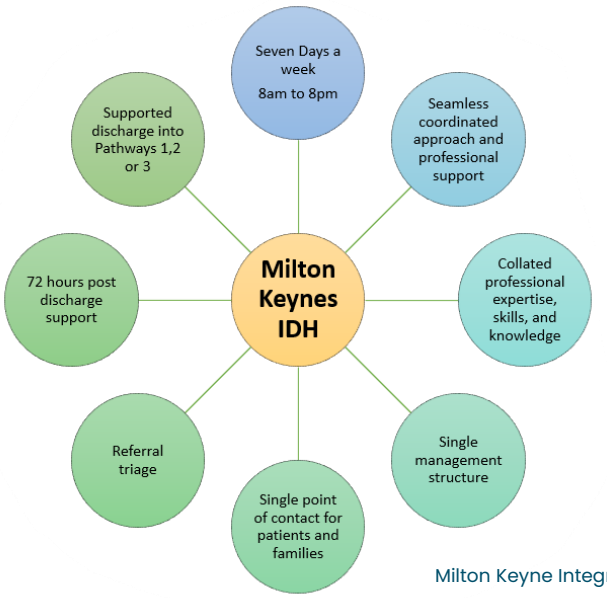
Across Milton Keynes, between 1,600 and 2,300 people are discharged from hospital each month. Across the 18-month period, 354 MRNs (patient contacts) were provided to us. Only 162 patients were contactable and able to participate. This was out of our control: barriers included incorrect contact numbers, readmissions, deaths, out-of-area placements, and patients reporting they had not been told about the project. These barriers are themselves part of the patient experience and reflect system-level issues in communication, data accuracy, and follow-up. Despite the smaller-than-intended sample, the consistency of themes across 18 months, across both pathways, and across multiple data sources gives the findings weight.

Executive Summary

> "I was rushed to the discharge lounge at 10am and left there for eight hours. Every time I asked what was happening, the nurse just shouted at me and told me to sit back down." (Patient, Pathway 1)

Across 18-months of insight, we found that patient experience did not show a sustained pattern of improvement. Feedback fluctuated and persistent themes remained. Communication was the most influential factor shaping participants' experience, affecting their understanding, confidence, and preparedness for discharge. Patients on Pathway 2, the intermediate community bed pathway, reported more consistent and positive experiences. Those on Pathway 1, which supports people to return home with care, described much greater variability.

The findings of this evaluation highlight a gap between system ambition and lived experience, driven largely by inconsistency in communication, coordination, and the delivery of support across multiple services. Addressing this gap is essential if the IDH is to fulfil its potential and deliver a consistently safe, predictable, and person-centred discharge experience.



Milton Keyne Integrated Discharge Hub Model

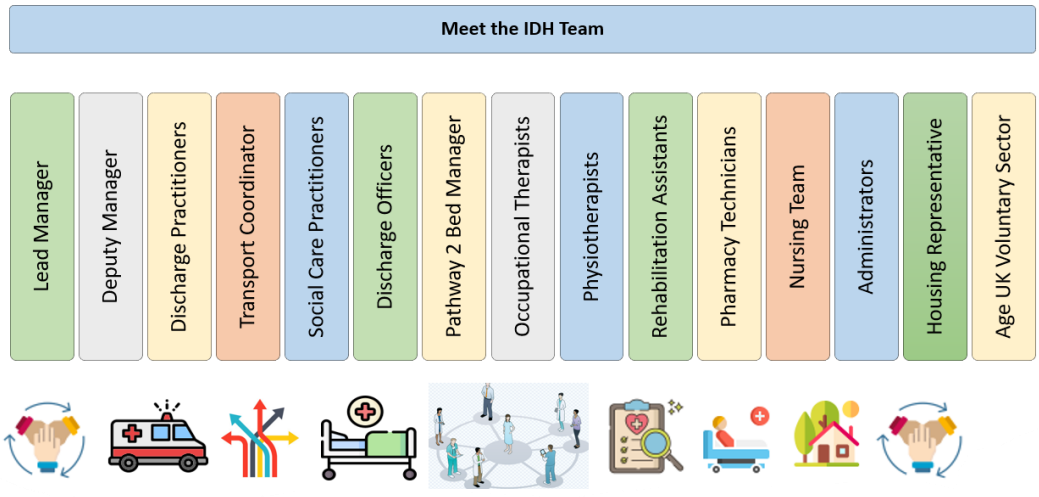
Introduction and Purpose of the Evaluation

Timely, informative and supportive discharge from hospital has been a long-standing area of concern for Milton Keynes residents with lived experience of admission to hospital. The recurring themes that we hear about are issues related to communication, delays, poor care coordination and inconsistent post-discharge support. We first evidenced these issues following our Enter and view visit of the Discharge Lounge at Milton Keynes University Hospital NHS Foundation Trust in 2017. Our 2023 report, *Improving System Flow: A Patient Perspective*, highlighted how the same challenges continue to affect people's experiences of care as well as their health outcomes.

Over this period, Milton Keynes has faced significant operational pressures, including having one of the fastest-growing ageing populations in the UK, rising demand for hospital and community services, and the lasting impact of the COVID-19 pandemic. With lengths of stay in MK Hospital above the national average, particularly for patients in hospital for more than 14 or 21 days, the case for a more joined-up, coordinated approach to discharge was clear.

System-mapping work carried out through multi-disciplinary teams of clinicians, social care and community services identified recurring issues: duplicate assessments, repeated questioning, miscommunication between services, unclear roles and responsibilities and a fragmented discharge process. Their findings very much align with concerns raised by residents.

National policy direction also encouraged change. The Government's Hospital Discharge and Community Support Guidance (2022) promoted the development of integrated discharge hubs, building on learning from the pandemic where reduced organisational barriers enabled more streamlined discharge processes. In Milton Keynes, this led to the proposal for an Integrated Discharge Hub. The IDH would be a single, coordinated model bringing together nursing, therapy, pharmacy, transport, housing and other specialist roles to provide a single point of access, and a single point of contact for patients and families. The ambition was to reduce duplication, improve communication, strengthen coordination, and ensure that patients were supported by the right professional, at the right time, to the right place.



Introduction and Purpose of the Evaluation

We were commissioned by Milton Keynes Health and Care Partnership, with support from the Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK ICB), to carry out an independent evaluation of patient experience during the implementation of the IDH. The purpose of this evaluation was to:

- Understand how patients experienced discharge through the new model, identify what was working well and where improvements were needed.
- Provide real-time insight to a steering group of professionals overseeing the implementation of the IDH.
- Support the system to refine and strengthen the discharge process.

Our evaluation focused on patients who were discharged through:

- Pathway 1, which supports people to return home with care; and
- Pathway 2, which provides short-term intermediate community beds.

We captured their experiences of discharge planning, communication, coordination and post-discharge support during a period of ongoing system development.

Our evaluation did not seek to assess whether the ambitions of the IDH were fully realised. Our focus was on assessing improvements to communication, information, post-discharge support, and the provision of community care across the life of the project from the perspective of the patient, and their carers.

Methodology and Approach

This evaluation project was designed as a mixed methods study, combining quantitative trend analysis with qualitative insight. We conducted structured telephone interviews with patients three to six weeks after discharge, allowing time for reflection on both the discharge process and the support received at home or in the community.

A total of **354** patient records were shared with us over the 18-month period, and **162** interviews were completed. The evaluation used a consistent interview framework across both pathways, enabling comparison over time and between pathways.

Findings were shared quarterly with the Improving System Flow Steering Group to support ongoing system development.

Data Access, Consent Process and Limitations

At the outset of the project, we explored the use of Public Task as the lawful basis for data sharing. This would have enabled the Integrated Discharge Hub team to share patient contact details with us directly, thus supporting a more independent and consistent approach to recruitment for patient interviews.

Following internal discussions within Milton Keynes University Hospital NHS Foundation Trust's Information Governance Team, this option was not progressed. Instead, the project proceeded under an IDH staff-led consent model.

Under this arrangement, IDH and ward staff were responsible for explaining the evaluation to patients, obtaining consent, recording this within internal systems, and forwarding details to Healthwatch MK. This process introduced several practical limitations that shaped the dataset.

The process relied on busy clinical and administrative teams. We had limited visibility of how consistently patients were approached, how the project was described, or how many individuals chose not to participate. This inevitably created some constraints around independence, as the organisation being evaluated also held responsibility for facilitating access to participants.

Operational pressures further affected the process. Periods of high demand, including times when the hospital was operating at OPEL 4, reduced staff capacity to support non-clinical tasks such as consent recording. Administrative turnover also meant that the process between Healthwatch MK and the IDH needed to be re-established several times, contributing to variation in referral numbers.

Pathway 2 referrals were particularly inconsistent, reflecting the complexity of discharge routes and differing levels of staff awareness. These factors resulted in lower and more variable referral volumes than originally anticipated. However, the **162** completed interviews represent a substantial and rich dataset, and the consistency of themes across the 18-month period provides a credible and robust evidence base for understanding patient experience.

Findings

Experience Across the 18 Month Period

We found that across 18 months, patient experience did not show a sustained pattern of improvement. Feedback fluctuated, with similar issues recurring throughout. The most striking distinction was between pathways: Pathway 2 experiences were generally more positive and consistent, and Pathway 1 experiences more variable and often more challenging.

> "I didn't know what was going on. They told me I could go home, then changed it three times. Nobody explained why." (Patient, Pathway 1)

> "Everyone was very helpful. I felt supported and knew what was happening." (Patient, Pathway 2)

Communication and Understanding of Discharge

Communication was the most influential factor shaping patient experience. Patients frequently described not knowing when they were going home, receiving conflicting information, or feeling excluded from decisions. Families — who often play a critical role in supporting recovery — were not always included in discussions.

> "Husband has dementia so didn't really understand, no-one from the hospital involved me in the plans for discharge, I was keen for him to come home but hadn't realised how much he had deteriorated. After main admission he went back to observation ward for a day with very high temperature, he was sent home with antibiotics and no-one had told me what for." (Patient, Pathway 1)

Where communication was clear, patients felt more confident and prepared. But these examples were less common.

Experience of Delay, Coordination and Discharge Day

Delays were a common feature of patient experience. Patients often described being declared "medically fit" but waiting hours or days to leave hospital, without clear explanation. These delays were experienced as uncertainty and frustration.

> "If you are told you are going home, [they should] let you go. I was told I could go on Thursday then was delayed until the following Tuesday. Apparently, it was because care wasn't available...on the day of discharge I was sent to the discharge lounge and didn't get home until 8pm. At one point I phoned my wife to say I hadn't been given anything to eat; she had to phone the ward and tell them I was diabetic and ask if they could give me a sandwich." (Patient, Pathway 1)

Findings

Pathway 1 – Variability, Complexity and Patient Impact

Pathway 1 is clinically robust in design but highly variable in practice. Patients often described uncertainty about what support they would receive, delays in equipment provision, inconsistent carer visits, and limited follow up from therapy services. This variability reflects the complexity of coordinating multiple community services.

> "I didn't know what support I was supposed to get. I was told I'd have therapy at home, but nobody came for weeks." (Patient, Pathway 1)

Pathway 2 – Consistency, Structure and Patient Confidence

Pathway 2 experiences were consistently reported as more positive. Patients often described clear communication, predictable routines, and a sense of being supported through recovery. The co-located nature of Pathway 2 services supports more reliable delivery.

> "I was informed of everything happening to mum - the social worker is keeping me updated." (Family member, Pathway 2)

Medication, Safety and Post Discharge Support

Medication issues were frequently reported. Patients described being given medication without explanation, receiving incorrect or incomplete prescriptions, or being unsure how to manage changes. The recurrence of these issues suggests potential safety risks, as well as patients not knowing how to manage their own care in ways that could reduce readmissions or prevent avoidable requests for Primary Care support.

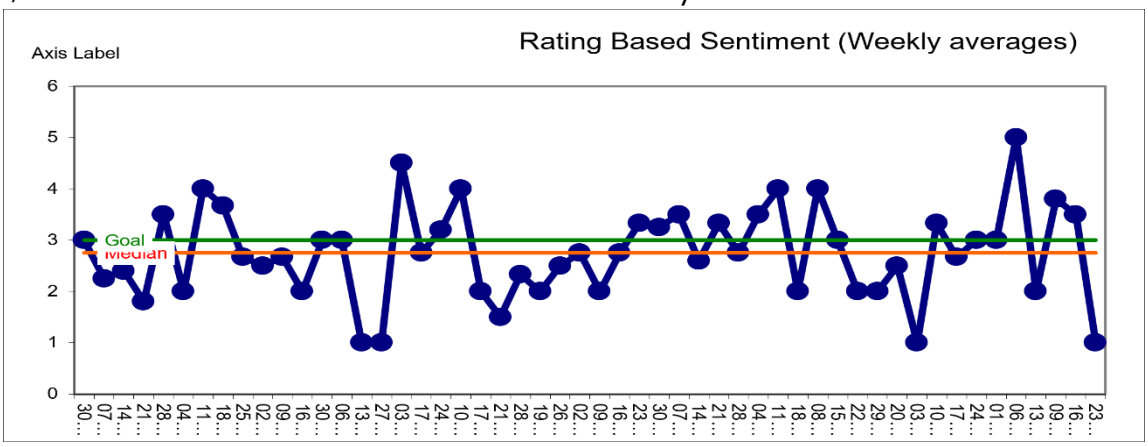
> "It was all rather chaotic. There was poor coordination between the ward and the pharmacy to get my medication, an ambulance came to take me home and had to leave because the tablets weren't ready, then another ambulance came and had to wait an hour but they still weren't ready so they took me home and my daughter had to get my medications. I still had no pain killers when I got home, my own medications which I took to the ward also disappeared, it's been really difficult for my GP to sort out the correct medications." (Patient, Pathway 1)

Despite variation in monthly referral numbers, the themes reported by patients were strikingly consistent across the full 18-month period. This consistency strengthens the reliability of the findings and highlights issues that are deeply embedded in the discharge process. Patients frequently reported not receiving clear written discharge information, which created uncertainty about what to expect once home. Providing consistent written guidance would significantly improve confidence and safety.

Findings

These run charts present the patient experience of the discharge process over time. They use both the IDH agreed rating scale (5= Excellent, 4= Very Good, 3= Good, 4= Fair, 5= Poor) and sentiment derived from free-text feedback. The intended standard is that experience should consistently reach at least 'Good'.

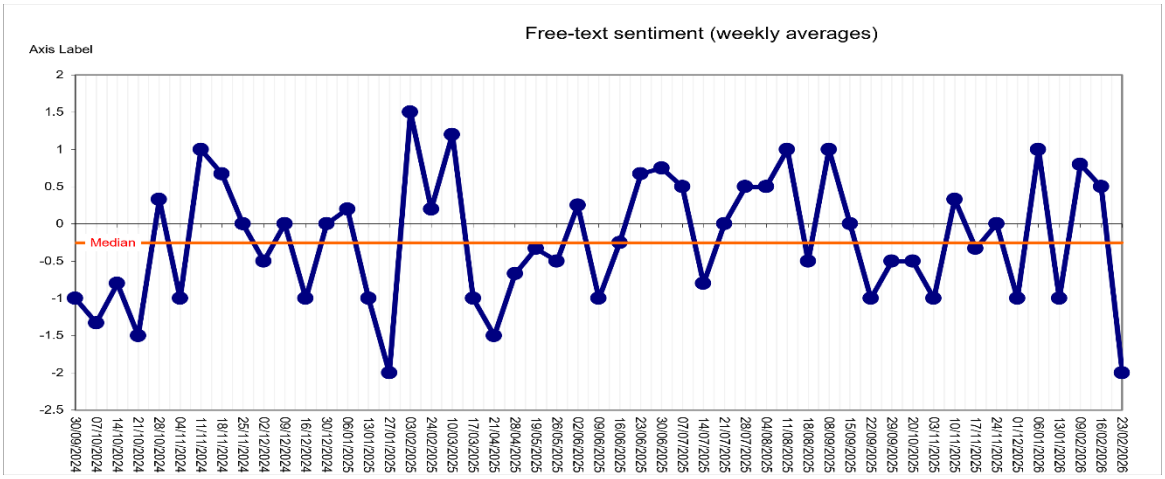
Throughout the project, experience does not show a sustained pattern of improvement. Rating scores fluctuate above and below the 'Good' standard, indicating variability rather than consistent performance. While there are periods where experience reaches 'Very Good' or 'Excellent', these are not maintained and are followed by decline.



The free-text sentiment analysis provides insight into this variation. Where comments were offered alongside the rating given, they were analysed by identifying positive language (e.g. *good, excellent, helpful*) and negative language (e.g. *poor, delay, lack, frustrating*), assigning scores of +1 and -1 respectively. These were combined into a sentiment score for each response, averaged by week, and plotted with a median line.

This reveals a stronger signal than ratings alone: many 'Good' or 'Fair' scores are accompanied by negative feedback, suggesting ratings may understate poorer experiences.
Recurring themes—communication gaps, discharge delays, unclear planning, and poor coordination—persist over time, indicating systemic rather than isolated issues.

Both charts show high variation, indicating an unstable process with unpredictable experience. Overall, performance is inconsistent, with the agreed 'Good' standard not delivered reliably. While positive outcomes occur, they are not yet routine, and issues with communication, coordination, and timeliness continue to impact patient experience.



Findings

Over the course of the evaluation, 32 patients told us that they had been readmitted to hospital after their discharge, some within 48 hours, and some having experienced multiple readmissions. These accounts emerged during follow-up interviews, as people described what had happened once they had returned home, and whether the support they expected had been in place.

These readmissions were identified solely through patient accounts, and the project did not seek to determine whether any individual case was avoidable or directly linked to the quality of discharge and post-discharge support. What the evaluation can comment on is how the system responds to these situations.

Across the 18-month period, we saw no visible, clear or consistent mechanism for reviewing readmissions in the context of a patient's earlier discharge experience. Patients who had returned to hospital did not describe being asked about what had happened at home, whether they had understood their discharge plan, or whether the support they were expecting had been delivered as intended.

This doesn't mean such reviews never take place. However, they were not evident within the experiences shared with us, nor were they visible through the system interfaces we engaged with.

The absence of a clear feedback loop means that opportunities for learning may be missed. Readmissions can offer valuable insight into whether discharge planning was sufficiently robust, whether communication was effective, and whether community support was in place at the right time. They can also highlight gaps in medication understanding, equipment provision, or the patient's ability to manage safely at home.

Having a structured, embedded approach to reviewing these cases within the IDH model will ensure that the system can identify patterns, understand contributing factors and use information to strengthen pathways. Strengthening this aspect of system practice would support ongoing improvement and help ensure that the intended benefits of the IDH are consistently reflected in patient experience.

Several patients also described a loss of mobility and confidence during their hospital stay, often linked to prolonged bed rest and limited access to physiotherapy. This had a direct impact on their readiness for discharge and their recovery at home.

Findings

What is working

- Positive staff interactions – some excellent individual staff were named
- Good experiences on Pathway 2
- Effective reablement teams
- Good experiences when communication did happen
- Many patients felt safe and supported

What patients say would have helped

- Written information
- Clearer explanations
- Consistent communication and more involvement of family
- More notice of discharge
- Better coordination between hospital and community
- Equipment delivered before discharge
- Somone to talk through the discharge plan
- A named person to contact

Conclusion and Recommendations

The IDH model is ambitious, well designed, and aligned with national policy direction. It reflects a clear system commitment to improving patient flow, reducing delays, and delivering more coordinated, person-centred discharge processes. The challenge is not the model itself but the consistency of its implementation during a period of ongoing development. Addressing communication, coordination, and reliability — particularly within Pathway 1 — will be essential to realising the full potential of the IDH.

Our recommendations are as follows:

Strengthening communication at every stage of discharge - Clear, timely communication underpins a safe and confident discharge. When information is inconsistent or unclear, patients feel uncertain even when clinical decisions are appropriate. Improving communication would have an immediate impact on patient experience.

Providing clear, written discharge information - Patients often struggle to recall verbal explanations given at the point of discharge. Written information supports understanding, enables families to help, and reduces the risk of confusion about medication, follow-up, and support.

Improving consistency in Pathway 1 delivery - Pathway 1 involves multiple services and handovers, which creates more opportunities for variation. Ensuring that core elements — communication, equipment, therapy, and follow-up — are delivered reliably would reduce the inconsistency seen in patient experience.

Ensuring reliable equipment provision and therapy follow-up - Delays or gaps in equipment and therapy undermine independence and confidence at home. Strengthening these processes would support recovery and reduce avoidable deterioration or return to hospital.

Strengthening medication safety processes - Medication changes are a common point of confusion. Clearer explanations and written information would improve safety, support adherence, and reduce anxiety for patients managing new or altered prescriptions.

Developing a structured approach to learning from readmissions - Readmissions offer valuable insight into whether discharge planning and community support were effective. A more systematic approach to reviewing these cases would help the system identify patterns and strengthen pathways.

Embedding partners more fully in the development and delivery of the IDH - There were missed opportunities during this project to involve Healthwatch more consistently. For example: in supporting the consent process, contributing to the analysis of patient experience alongside improvement plans, and participating more fully in the core system flow meeting structures. Earlier and more integrated involvement of partners would strengthen shared understanding, improve the quality of insight available to the system, and provide the IDH with broader support as it continues to develop.

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