healthwatch Cheshire West

Discharge from Hospital

Phase 1: Pre-Discharge

June 2026

Contents

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 May 2026, **Healthwatch spoke to 26 Cheshire West and Chester 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 more than twelve weeks.

What we found

Overall, patients were positive about the care they received on the wards, with the kindness and dedication of staff highlighted consistently. However, 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 for many patients, though a few were navigating the process largely alone. The majority 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 most patients felt ready to leave, this was sometimes based on a general understanding rather than a clear picture of what would happen after discharge. Uncertainty about timings, care arrangements, and practical support remained for some. For those being discharged to a care home, a lack of information about the destination added to their anxiety.

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 the Healthwatch Cheshire West website and shared with Mid Cheshire NHS Trust, Cheshire West and Chester Council, and Cheshire and Merseyside Integrated Care Board (ICB).

Introduction

What is Healthwatch Cheshire

Healthwatch Cheshire West is the independent advocate for people who use health and social care services in Cheshire West and Chester. As part of our core activity, 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 West 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 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 26 Cheshire West residents at Leighton Hospital across 21 visit dates between 11 November 2025 and 7 May 2026.

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. All 26 conversations were completed in full, and the findings draw on all 26 responses. 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.

Findings

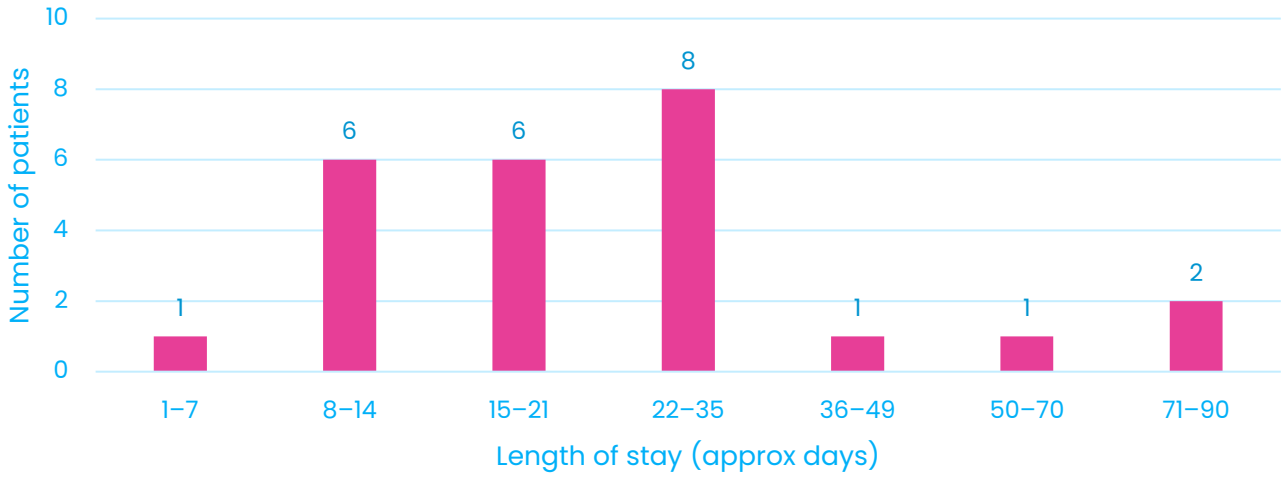
Context before discharge

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

Admission and length of stay

21 out of 26 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 or elective admission, of which one person said they had been told how long they would be in hospital.

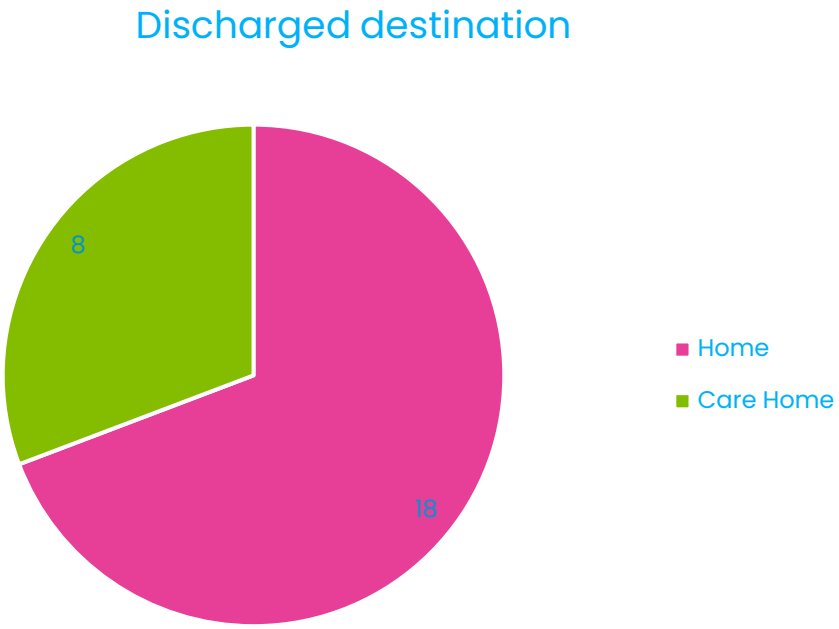
Lengths of stay ranged from **four days to twelve weeks**. Many patients had been in hospital for two to five weeks, while others had stayed for six weeks or longer. For those with longer stays, the news that they were going home felt sudden, even when discharge had been under discussion for some time.



Discharge process and destination

25 out of 26 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.

18 out of 26 people were going home. Eight were going to a care setting - seven to a new setting, and one returning to their usual care home.



What patients told us: context

One patient was brought to Leighton by air ambulance following an emergency operation abroad. During a nine-week stay, they described mixed messages and poor communication between teams throughout. The night before discharge, they were moved at midnight to a rehabilitation ward — where no rehabilitation took place. They were then moved to the discharge lounge the following day. Even at the point of discharge, they were still waiting to confirm that wound care had been properly arranged.

One patient was told the day before discharge that they were moving to a care setting. The two options they would have preferred — Elmhurst and the hospital's own rehab ward — had not been available. The option they were offered felt uncertain at first. They said that if they had refused it, they would have been put to the back of the queue, and it 'felt a bit pressured.' By the time they spoke to Healthwatch, their mental health had been 'going down' in the preceding week. After doing their own research, they accepted the destination — but said that more notice would have made a real difference.

A patient was unexpectedly discharged to a care home they had not chosen and knew little about. They described learning about the destination as a shock. They had been given the name of the facility, but nothing else about what to expect once they arrived.

One patient spent three nights in the Discharge Lounge without being told why there was a delay. They had not been given any written information about the discharge process. During the visit, Healthwatch staff noticed a discharge information sheet on the cabinet beside the patient — out of reach and out of sight. When it was passed to them, the patient said they

had not known it was there. They had not been seen by a physiotherapist or occupational therapist during their stay.

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

16 out of 26 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 patients could not get answers easily, some waited a long time after using the call bell. Others were told staff would come back — and then waited again. In a number of cases, family members ended up chasing information on the patient's behalf. For some, the challenge was not a shortage of staff contact, but the lack of a consistent person to talk to — lots of different faces, different information, and no clear thread to follow.

Written information

22 out of 26 people said they had not been given written information about discharge. In two of the remaining cases, written information was either stored with the patient's medication and had not been seen, or was present at the bedside but had never been pointed out to the patient.

Where written information was given, it tended to be about the care home a patient was moving to — for example, a leaflet describing what the facility is like rather than about the discharge process itself, such as medication, follow-up care, or who to contact with questions.

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

Support after discharge

24 out of 26 people said they knew about support planned after discharge. For most, this was a care package at home — carers visiting several times a day, in some cases alongside a district nurse or community therapy follow-up.

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. For those going to a care setting, several were unsure what the level of support would involve in practice — including whether specific equipment would be available, or what rehabilitation would look like once they arrived.

Did information meet needs?

17 out of 26 people felt the information they received met their needs. Nine said it did not. For those people, timing was often the issue — information came too close to discharge, arrived in pieces, or changed before it could be acted on.

For patients being discharged to an unfamiliar care home, the information gap was often about the destination itself. Several people had been given a name or shown a brochure, but had no real sense of what daily life or their level of support would look like once they got there.

One patient noted that they needed to know what to ask to find information. The information was available, but only if one knew to look for it.

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 3 out of 26 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. Several patients described mixed or negative experiences with social workers from previous admissions, which had shaped how they thought about the role.

Family/carers involved
18 out of 26 people had family or carers involved. They spoke with staff, helped coordinate plans, and were often a key point of contact for updates. Eight people had no family or carers playing an active role — some through choice, some because family were not nearby, and some because they were managing the process independently.

Several patients whose family were involved described communication flowing through them rather than directly between the hospital and relatives. In those cases, the patient was effectively acting as a go-between for their own discharge planning.

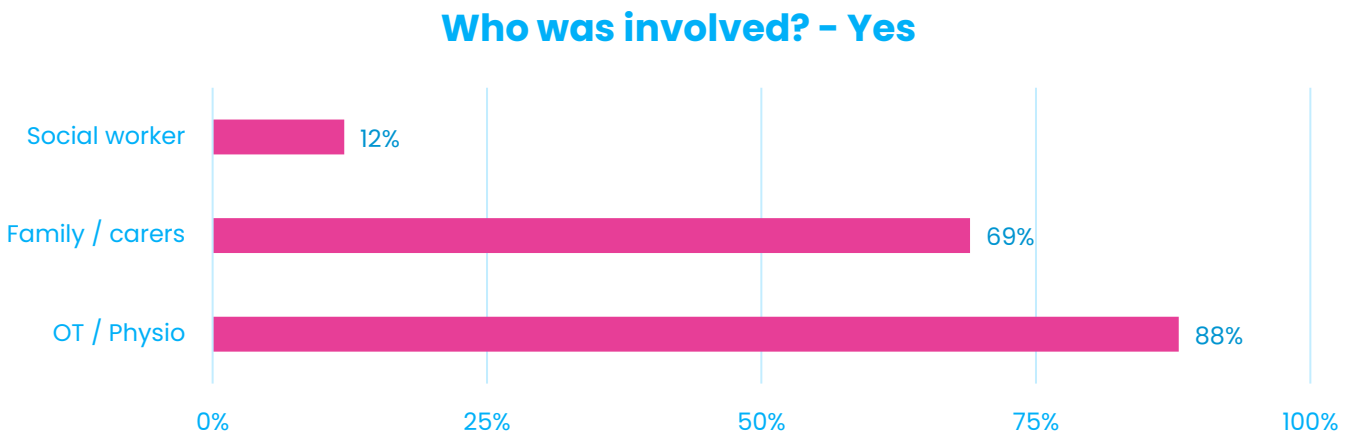
Occupational Therapist (OT) or Physiotherapist
23 out of 26 people had seen an occupational therapist or physiotherapist during their stay. For most, this involved some combination of mobility work, exercises, and an assessment of equipment needed at home. Three people had not been seen by either.

The high figure, though, does not fully capture the picture. Several patients who had received therapy input still left hospital with unresolved mobility concerns. One patient left unable to walk — a capacity they had had on admission, twelve weeks earlier. Another had a physio appointment scheduled that was never actioned; the Healthwatch representative asked at the nurses' station and was told it had been missed and would be chased.

One patient described how they had pushed through pain during physio sessions to show they could manage.

'I was told I was doing so well but I had pushed through the pain. Almost did it too well when I should have been more honest about how hard it was.'

They reflected that this may have given an inaccurate picture of how ready they were to go home.



What patients told us: information and support

One patient had been in hospital for nearly three months without a designated staff member they could consistently turn to with questions. Lots of staff came and went, giving different information at different points. Their daughters had taken on much of the chasing for information, a role that felt like it should have been managed by the team.

A patient going home discovered, partway through their admission, that they lived outside the Trust's geographical area — which meant the care package had to be arranged through a different route. Once resolved, they were able to go home, but the confusion had added time and uncertainty to a process that had already felt unclear.

One patient was leaving hospital with a wound that had only been properly treated after they made a formal complaint during their admission. On the day of discharge, they were still waiting for confirmation that district nurse visits had been set up. They described the discharge as disjointed — different staff, different messages, no clear sense that the people involved were speaking to each other. 'It doesn't appear that people are talking to each other.'

A patient who could not read or write described their social worker as ‘brilliant’ — someone who helped with practical things like shopping and reading letters. Yet all their discharge information was given verbally. No alternative format had been arranged, and they had no way to refer back to what they had been told or check what had been agreed.

Readiness for discharge

24 out of 26 people said they felt prepared to leave hospital. Two did not. Their concerns included being unable to walk in the way they had been able to before admission, and not feeling well enough (or comfortable enough) to manage at home.

Concerns about discharge preparation

18 out of 26 people did not raise [significant] concerns about how their discharge was being prepared. For most, 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 felt ready. For some, a care package was in place but the detail had not been confirmed — who would be providing it, when it would start, and whether anyone would be there when they arrived.

Eight people raised concerns. Those concerns fell into three broad areas: mobility and physical readiness; uncertainty about what support would actually look like once home; and, for those going to a care home, anxiety about a destination they had not chosen and knew little about.

Were concerns dealt with appropriately?

For most people this question did not apply, as they had no concerns to raise. Of the eight who did, four said their concern did not directly relate to the discharge process — it was about clinical outcomes, practical logistics, or worry about the impact of their care on someone close to them. One person said their concerns had been addressed; staff had taken the time to explain the destination and offer reassurance.

Three people said their concerns had not been dealt with appropriately. In two of those cases, ward staff themselves had expressed concern — and said so to the patient — but nothing changed as a result. In one case, the discharge was described as rushed and disorganised, and the ward team acknowledged that. In the other, the patient did not feel well enough to go home and believed a different setting would have been more appropriate — a view the ward team was said to share. In both cases, the concern was recognised and voiced. Neither led to any change in plan.

What patients told us: readiness for discharge

One patient had been able to walk, with support, before their admission. Twelve weeks later, they were leaving hospital by hoist, unable to do so. They had raised the lack of physiotherapy input with staff but felt this had not been properly addressed. They were going home with a full care package, but had no plan in place for how they might regain their mobility.

A patient described going home on the same medication they had come in on — medication that had not been managing their pain on admission.

They had pushed through discomfort during physiotherapy sessions to demonstrate they could cope, and later reflected this had not been an honest picture of their capability. They felt a short period of respite in a care setting would have been more appropriate. Ward staff were said to agree.

One patient said they were ready to go home, but their biggest concern was whether wound care had been properly arranged. During their admission, they had needed to raise a formal concern through PALS before their wound received proper treatment. By the day of discharge, they still did not know whether district nurse visits had been confirmed.

A patient being discharged to a care facility said they had no choice but to be ready. They wanted to go home and understood why that was not yet possible — but the acceptance was reluctant. They had no idea how long their stay at the facility would last.

One patient was going home with a care package for the first time, after six weeks in hospital. They had been told about the discharge the night before, which did not feel like enough time to prepare. They knew support was in place but not the detail — who would be providing it or when it would start. They had raised a concern about managing their stairs and felt an extra handrail would help, but nothing had been arranged before they left.

Overall experience

Communication about discharge date

23 out of 26 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 changing, plans being pushed back, or communication that was reactive rather than structured. Some received a series of updates over a couple of days; others were told the day before, then again on the day. Two people said they had not been kept informed — in both cases, they described a process that felt disjointed, with mixed messages and no clear single point of contact.

Transport

16 out of 26 people were travelling home by ambulance. Six were travelling by British Red Cross or other arranged transport. Three were going by car with a relative. One was not sure. For those relying on arranged transport, the timing was often uncertain — people knew something was coming, but not when. That left some sitting and waiting without knowing whether it would be an hour or much longer.

Waiting to leave

For many patients, the discharge experience was shaped by what happened in the final hours — and for some, the final night — before they went.

Several people described spending extended periods in the discharge lounge, including overnight stays. By the time discharge came, some were exhausted. Patients mentioned poor sleep, noise, and discomfort while waiting. Some had been moved to the lounge before all the arrangements were in place, and waited there for the pieces to come together. Some described the environment itself as difficult — no natural light, poor ventilation, and concerns about cleanliness. For some, the difficulties had started on the ward before they reached the lounge, with noise and disruption making the wait harder still.

Overall rating

11 people rated the support and care they received as very good. Eight rated it as good, six as average, and one as poor.

Patients who gave high ratings often still described difficult moments alongside them — long waits in the lounge, a sense of the system stretched around them, and discharge processes that felt hurried or incomplete. Several reflected that it felt unfair to criticise individual staff given the conditions they were working in. As one put it: 'staff are busy — they haven't got time to talk to you.'

The most consistent theme across the positive accounts was the quality of relationships with ward staff. People described feeling genuinely known — staff who took time, remembered things about them, and made them feel cared for even when everything else was under pressure. One patient said the nursing staff had been 'spot on' throughout their stay and described feeling genuinely looked after.

The average ratings reflected a range of experiences — varying between day and night shifts, long waits for call bell responses, and parts of discharge that had felt poorly managed. The one poor rating followed an experience of feeling dismissed and ignored by a member of the therapy team — something that, for a patient who relies entirely on verbal interaction, had shaped how supported they felt throughout.

One patient experienced repeated delays in receiving pain relief throughout their stay, which they found distressing. They asked Healthwatch to pass their experience back to the specific ward through the feedback centre.

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

What patients told us: overall experience

One patient came home after a procedure that had resolved a long-standing problem affecting their ability to eat. ‘When you know you’re going home it’s super, I’m going home a different fella, I can eat again now.’ They attributed this to the care team around them, and could not have been more positive about the ward staff.

A patient who had experienced a stroke described an exceptionally well-coordinated discharge. They had been seen every day by both physiotherapy and occupational therapy, accompanied on a home visit to assess what adaptations would be needed, and their family had received formal carer training. The Stroke Association had visited them on the ward. They described the whole process as exceptional and could not have praised the ward staff more highly.

One patient described the daytime care on the ward as very good, but noted a stark contrast with the night shift. They have Parkinson’s disease and had warned staff that a standard bottle would not be sufficient for their night-time toileting needs. As they put it: ‘they are very reluctant to let you go to the toilet and will also tell you to use a bottle. I know I will wet the bed due to my Parkinson, so I have to argue with them. Last night they would only give me a bottle and then sure enough I wet the bed.’ Staff also started to undress them for bed without asking. The daytime care had been very good. The night shift was, in their words, terrible and had been from the start.

A patient described going through five wards in twelve days. Despite the disruption, they said information had been handed over effectively at each point and they felt supported throughout. 'I have been well informed and well looked after, all has been ok.'

One patient described ward staff as kind and supportive throughout a five-week stay, saying they had been able to lift their spirits at a difficult time. Earlier in their admission, some staff had been abrupt about going home before a care package was fully in place. When the consultant took over the discharge conversation, that changed — they were thorough and reassuring, taking time to explain pain management and what to expect after leaving.

One patient rated care as very good, and said so plainly: 'I have nothing to complain about. It's just the last part — the discharge.'

Service Provider Response

Mid Cheshire Hospitals NHS Foundation Trust welcomes this report from Healthwatch Cheshire and the insight it provides into the experiences of Cheshire West and Chester residents preparing to leave Leighton Hospital. The report reinforces the importance of seeing discharge not as a single hospital process, but as a shared responsibility across health, care and community services.

It is encouraging that patients consistently recognised the kindness, professionalism and commitment of colleagues across our wards and services. These experiences reflect the care and compassion shown by teams every day, often while supporting people with increasingly complex needs.

The findings also highlight opportunities to strengthen communication, information sharing and coordination across organisational boundaries. Many of the issues raised extend beyond the hospital setting and require a joined-up approach involving acute, community, primary care, social care and voluntary sector partners to ensure people experience a seamless transition from hospital to home or another care setting.

Improving discharge remains a key priority for the Trust and for partners across our health and care system. Through our Integrated Discharge Team and wider system partnerships, work is already underway to improve patient and carer involvement, strengthen communication, enhance coordination of post-discharge support and reduce avoidable delays across the whole discharge pathway.

Healthwatch Cheshire's work provides valuable insight into the lived experiences of local residents and will help shape ongoing improvement activity across the system. The findings from this first phase will be considered alongside future stages of the project to build a fuller understanding of how discharge arrangements translate into outcomes and experiences once people leave hospital.

- 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 West and Chester 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

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