healthwatch Staffordshire

Hospital Discharge

Winter 2024 to 2025

Contents

Introduction

"Hospital discharge is the final stage in an individual's journey through hospital following the completion of their acute medical care, when they leave an acute setting and move to an environment best suited to meet any ongoing health and care needs they may have.

This can range from going home with little or no additional care (simple discharge), to a short-term package of home-based or bed-based care and recovery support in the community, pending assessment of any longer-term care needs (complex discharge).

Whether at home or in a community setting, individuals should be discharged to the best place for them to continue recovery (if needed) in a safe, appropriate and timely way". (Hospital Discharge and Community support Guidance updated 2024*).

*https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance

Every winter, the NHS is under pressure to free up beds. When the NHS correctly discharges patients from a hospital to their homes or another care facility, it can aid their recovery and free up beds for new patients.

According to an article from Healthwatch England*, for this to happen, hospitals are supposed to ensure that patients:

- are medically fit to leave the hospital
- have the information they need
- have any care and support they need in place
- are involved in the planning for their discharge.

*https://www.healthwatch.co.uk/news/2025-02-04/hospital-home-improving-patient-discharge

However, getting hospital discharge wrong can harm both patients and services. In this Deep Dive study, we examine what people in Staffordshire have told us about leaving hospital, and the lessons that can be learned to improve the support patients get within Staffordshire.

This Deep Dive complements our recently published reports on patient experiences of using the Emergency Ambulance Service and on the use of Admission Avoidance Schemes. These reports have already highlighted some of the challenges of co-ordinating and maintaining patient flow through the Staffordshire healthcare system, some of which also apply to Hospital Discharge Schemes.

National Guidance on Hospital Discharge

The Department for Health and Social Care, in it's updated Statutory Guidance on Hospital Discharge and Community Support, outlines the best practice guidelines for hospital discharge planning and community support for patients, post-discharge. These include:

Early Discharge Planning

- Early discharge planning is essential, from admission for emergency cases, and prior to elective admissions.
- Involvement of patients, family members, and unpaid carers is crucial for informed decision-making.
- The Health Care Act 2022 mandates early planning for those needing health and/or social care support post-discharge

Discharge Processes

- Patients no longer needing inpatient care should be discharged safely and promptly.
- Local areas should adopt discharge processes tailored to their population's needs, including Discharge to Assess (D2A) and Home First models.
- A single co-ordinator should oversee the discharge agenda across the health and social care system.

Pathways for Discharge

- Discharge home is the default pathway for patients on Pathways 0 & 1.
- Patients may also be transferred to non-acute settings (Pathways 2 & 3).
- Case Managers should be assigned to those needing support post-discharge to facilitate recovery.

Discharge Timing

- Patients should be discharged as soon as it is safe after a medical decision, ideally before 5pm.
- Co-ordination with family members and onward care providers is essential for a smooth transition.

Role of Managers

- Managers should co-ordinate care input in non-acute settings, primarily in patients' homes.
- Dedicated staff should manage Pathway 0 discharges, while the Transfer of Care Hub should oversee Pathways 1, 2, & 3.
- Adequate capacity among Case Managers is necessary for monitoring recovery and assessing long-term care needs.

Work Flexibility

- Staff should work fluidly between community settings and acute trusts based on demand and capacity.
- Coverage is required seven days a week, leading to potential adjustments in work hours.

Staffordshire and Stoke Integrated Care Board Operational Plan 2024/25

The ICB clearly set out its commitments to improving hospital discharge in line with national guidance as set out below,

• Improve hospital discharge pathways, increasing Pathway 1 and further reducing of Pathway 2 and 3 discharges from Quarter 2 onwards.

• Post-hospital we will deliver a consistent seven-day service and improve the discharge profile and targets by Quarter 4.

• Enhance the quality and timeliness of discharge for patients eligible for ongoing end of life community care support throughout 2024/25.

• Develop and grow opportunities for the VCSE sector in discharge pathways by Quarter 2.

• Ensure consistent operational utilisation of the Choice Policy across our system.

• Utilise virtual wards consistently across all parts of the County and ensure utilisation is consistently above 80% throughout 2024/25 by Quarter 2.

Local Discharge Procedures

We met with the two Integrated Hospital Discharge Managers and clinical leads for North and South Staffordshire from Midlands Partnership Foundation Trust (MPFT) Discharge Hubs to discuss local arrangements for discharge of Staffordshire patients.

We were told that there are two teams responsible for hospital discharge. One covers the North of the county and the other the South. Although they work in accordance with the NHS guidance on hospital discharge and local discharge procedures, the services are not delivered in exactly the same way, due to warranted variation. The main variation is that the majority of the patients that the South team support are in 'out of county' acute hospitals. Therefore, the team are community based.

The aim of the teams is to move patients out of acute care beds as soon as they are medically optimised, this is done under the 'Discharge to Assess' (D2A) process, either supporting people at home through Home First or using the D2A beds in care homes or the local community hospitals. Typical hospitals are Cheadle Hospital or The Haywood Hospital in the North and Samuel Johnson Hospital or Sir Robert Peel Hospital in the South. There are also some block booked care home beds across the North and South used for D2A.

Referrals in the North are processed by the Integrated Discharge Hub at Royal Stoke or County Hospital. In the South, they go into a central hub based in Great Wyrley where the discharge team is based. The aim of the D2A assessment is to look at achieving maximum independence as soon as possible. D2A involves a short-term care programme aimed at promoting independence. This may involve an assessment and set goals by a physio or occupational therapist to include exercises and tasks to achieve these. The teams are supported by social workers, with MPFT providing home care support via the Home First service; most assessment services are available within 24 hours.

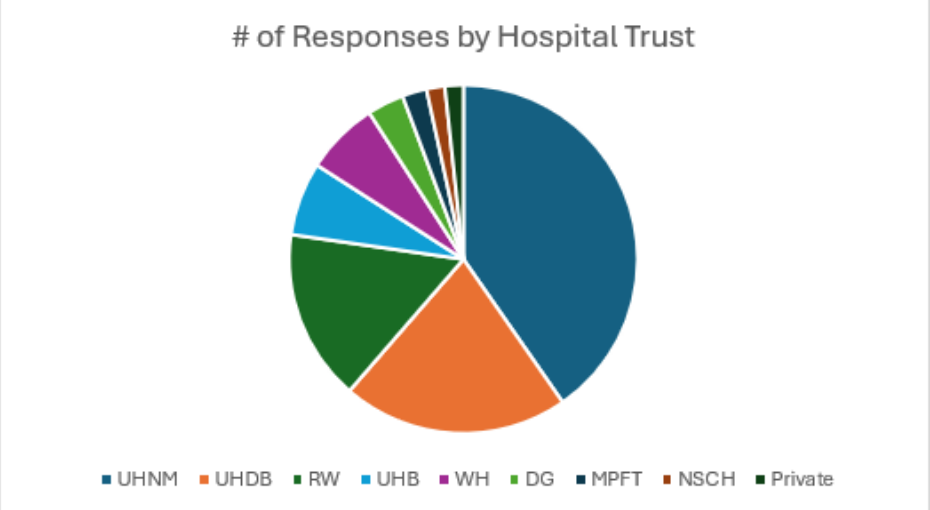
Discharge information packs are available but used as a tool in conversation with patients. Parts of the pack rather than the whole may be given to patients and relatives, if relevant. We were also told that if a patient has capacity, then a family member may not necessarily be involved in, or informed about, the discharge. This will always be at the patient's discretion, where they have capacity to make that decision. Managing family and patient expectations about discharge options available to them can be a challenge. Balancing the needs of the hospital to create capacity and flow, whilst managing family and patient expectations is a fine line, with staff requiring constant support to convey updates to patients and families.

Survey on Hospital Discharge for Staffordshire Residents

The following survey focuses on patients' experiences prior to admission, during their admission, the discharge itself and post-discharge. Our aim in undertaking this survey was to:

- Gather the patients' experiences of planning for discharge, delays during discharge and causes of discharge delays.
- Understand the patient's involvement in the decisions made about their discharge from the hospital.
- Evaluate the effectiveness of the discharge plan for patients and their families/carers in relation to their needs.

This survey was undertaken from the end of November to mid-February, with the aim of capturing patient experience of the discharge process over that period. There are a total of 171 responses. These were distributed across Staffordshire and neighbouring Hospital Trusts as follows:



Section 1: Introduction

1. Who is completing the survey?

	Answer Choices		Response Percent	Response Total
1	The patient (person who went into hospital)		47.90%	80
2	A family member or unpaid carer		40.72%	68
3	A paid carer providing care in the patient's home		1.80%	3
4	A paid carer in a care home		4.79%	8
5	Other (please specify):		4.79%	8
			answered	167
			skipped	4

2. In which Council area does the patient live?

	Answer Choices		Response Percent	Response Total
1	Staffordshire Moorlands District		12.50%	21
2	East Staffordshire Borough		11.90%	20
3	Stoke on Trent City		10.12%	17
4	Newcastle under Lyme Borough		6.55%	11
5	Lichfield District (including Burntwood)		7.74%	13
6	Tamworth Borough		4.76%	8
7	Stafford Borough		14.29%	24
8	South Staffordshire District		20.24%	34
9	Cannock Chase District (including Rugeley)		9.52%	16
10	Outside Staffordshire		2.38%	4
			answered	168
			skipped	3

Section 2: Before the Patient Went into Hospital

3. Before the patient was admitted to hospital, were they living ...

	Answer Choices	Response Percent	Response Total
1	In their own home (alone)	49.12%	84
2	In their own home (with family)	39.18%	67
3	With relatives	3.51%	6
4	In a care home (temporarily)	0.58%	1
5	In a care home (permanently)	7.60%	13
6	Other (please specify):	3.51%	6
		answered	171
		skipped	0

4. Was the patient in receipt of a care package within their home? This means did paid carers come into the patient's private home to help with personal care such as washing, dressing, preparing meals or taking medication?

	Answer Choices	Response Percent	Response Total
1	Yes	26.90%	46
2	No	64.91%	111
3	Not sure	8.19%	14
		answered	171
		skipped	0

5. Was the patient's home adapted and did they have the equipment needed to live independently?

	Answer Choices	Response Percent	Response Total
1	Yes	39.18%	67
2	No	50.88%	87
3	Not sure	11.70%	20
		answered	171
		skipped	0

84 lived alone, of these 45 were OK living alone, 26 had both carers and adaptations, 12 had just adaptations and 1 just had carers.

Section 3: Questions About the Patient's Stay in Hospital

6. Was the patient's hospital admission				
Answer Choices			**Response Percent**	**Response Total**
1	Planned		26.35%	44
2	Unplanned		73.65%	123
			answered	167
			skipped	4

7. Which hospital was the patient admitted to?				
Answer Choices			**Response Percent**	**Response Total**
1	Royal Stoke Hospital		32.16%	55
2	Harplands Hospital, Stoke		1.75%	3
3	County Hospital, Stafford		9.36%	16
4	St George's Hospital, Stafford		0.00%	0
5	Queen's Hospital, Burton		16.96%	29
6	Derby Royal Hospital		3.51%	6
7	Good Hope Hospital		5.26%	9
8	Walsall Manor Hospital		7.02%	12
9	New Cross Hospital, Wolverhampton		15.20%	26
10	Russell's Hall Hospital, Dudley		3.51%	6
11	Other (please specify):		9.36%	16
			answered	171
			skipped	0

*Other hospitals include private hospitals (Little Aston and Nuffield) as well as Samuel Johnson, Sir Robert Peel, The Haywood, Cannock, Royal Derby and Heartlands Hospitals.

8. When was the patient discharged from hospital?				
Answer Choices			**Response Percent**	**Response Total**
1	In the last month		37.72%	63
2	between 1 and 3 months ago		26.35%	44
3	between 4 and 6 months ago		8.98%	15
4	between 6 and 12 months ago		16.17%	27
5	Other (please specify):		10.78%	18
			answered	167
			skipped	4

9. How long was the patient's stay in hospital?				
Answer Choices			**Response Percent**	**Response Total**
1	admitted and discharged on the same day		7.83%	13
2	between 1 and 2 nights		15.06%	25
3	between 3 and 7 nights		36.14%	60
4	between 1 and 2 weeks		17.47%	29
5	between 2 and 4 weeks		14.46%	24
6	longer than 4 weeks		9.04%	15
			answered	166
			skipped	5

Section 4 About the Planning for the Hospital Discharge

10. Following admission to hospital was the patient given a discharge pack explaining the process of planning for their discharge?				
Answer Choices			**Response Percent**	**Response Total**
1	Yes		25.29%	43
2	No, but discussed verbally		34.71%	59
3	No and not discussed verbally		27.65%	47
4	Not sure		12.35%	21
			answered	170
			skipped	1

11. If Yes how long after your admission did you receive this?				
Answer Choices			**Response Percent**	**Response Total**
1	Day 1		11.49%	17
2	Day 2-3		10.81%	16
3	Day 4-7		14.19%	21
4	Day of discharge		12.84%	19

25% of patients were given an information discharge pack titled 'Your Hospital Discharge Explained' or parts of it. This is available for all patients but must be printed off on a computer by ward staff and is quite lengthy. 34% stated that they were not provided with written information, but this was discussed with them verbally. However, over 27% of patients said that they were not provided with written information, nor was it discussed with them verbally. These results fit broadly with the information we were given regarding the issuing of an information pack to all patients, which currently occurs on an ad hoc needs basis.

According to the current good practice guidance on hospital discharge:

> ICBs should ensure that services follow existing hospital discharge guidance. This guidance includes:
>
> - Supporting people in making informed choices by providing contact information and advice and asking about transport home.
> - Signposting to support services, including voluntary organisations and services that support unpaid carers.
> - Having clear responsibility for who will arrange people's transport home, with dedicated staff in place to make travel arrangements.
> - Providing a point of contact for people to use if their condition worsens.
> - Involving family and carers in decisions about someone's discharge.

https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance

12. On admission was the patient given an estimated date when their treatment would be finished and they would be discharged?

	Answer Choices	Response Percent	Response Total
1	Yes	31.74%	53
2	No	50.90%	85
3	Not sure or not applicable	17.37%	29
		answered	167
		skipped	4

13. After being admitted to hospital, did the medical/nursing team discuss with the patient any plans for returning home?

	Answer Choices	Response Percent	Response Total
1	Day 1	13.77%	23
2	Day 2-3	13.77%	23
3	Day 4-7	24.55%	41
4	Day of discharge	13.77%	23
5	It wasn't discussed	17.96%	30
6	Don't know/not sure	16.17%	27
		answered	167
		skipped	4

14. Did the patient and their family feel fully involved in decisions made about their discharge from hospital?

	Answer Choices	Response Percent	Response Total
1	Yes	47.62%	80
2	No	42.26%	71
3	Not sure	10.12%	17
		answered	168
		skipped	3

15. Did hospital staff take into account the patient's family or home situation when planning the discharge?

Answer Choices		Response Percent	Response Total
1	Yes	53.01%	88
2	No	33.73%	56
3	Not sure	13.25%	22
		answered	166
		skipped	5

16. Did the patient and their family feel informed of and involved in their care plan that was put in place to support them after discharge? (A care plan is the document that outlines the patient's assessed health and social care needs and how they will be supported after discharge.)

Answer Choices		Response Percent	Response Total
1	Yes	44.38%	75
2	No	41.42%	70
3	Not sure	14.20%	24
		answered	169
		skipped	2

17. Was the patient or their family able to discuss with the discharge team or staff member, any worries or concerns about their discharge?

Answer Choices		Response Percent	Response Total
1	Yes	53.25%	90
2	No	38.46%	65
3	Not sure	8.28%	14
		answered	169
		skipped	2

Section 5: The Patient's Discharge Experience

18. Where was the patient discharged to?

	Answer Choices		Response Percent	Response Total
1	Own home		75.63%	121
2	Relative's home		6.25%	10
3	Care Home (temporary)		5.63%	9
4	Care Home (permanent)		8.75%	14
5	Community hospital		3.75%	6
			answered	160
			skipped	11

19. On the day of discharge was the patient taken to the discharge lounge to wait for transport or medication?

	Answer Choices		Response Percent	Response Total
1	Yes		37.95%	63
2	No		46.99%	78
3	Not sure		15.06%	25
			answered	166
			skipped	5

20. Was the discharge delayed for any reason whilst you were waiting to leave hospital?

	Answer Choices		Response Percent	Response Total
1	Yes		42.94%	70
2	No		42.33%	69
3	Not sure		14.72%	24
			answered	163
			skipped	8

21. If Yes, what was the reason for any delay?				
Answer Choices			**Response Percent**	**Response Total**
1	Medication delay		67.53%	52
2	Transport delay		20.78%	16
3	Care package reinstatement delay		2.60%	2
4	Other (please specify):		40.26%	31
			answered	77
			skipped	94

Awaiting medication was by far the most reported reason for delays (52) with individual reports of waits up to 6 hours. In one case, the delay resulted in the patient having to be returned to the ward for the weekend as they were due to be newly admitted to a care home on a Friday afternoon. Care Homes do not accept new residents from Hospital after 5pm on a Friday.

"Meds were delayed and we had to wait 3hrs to take home, this affected work commitments and all we were told was that he'd be in a taxi if we couldn't stay, even though it was their delay."

Transport issues accounted for some (16) delays, often alongside waits for medication.

A further 33 reported delays were caused by a variety of issues including; communication issues with relatives and patients waiting for doctor sign off, funding decisions, assessment delays and access to a wheelchair.

"Father-in-law stayed in his bed/chair, dressed ready for discharge. We were not contacted to collect him as we requested, so visited at 6pm in the evening with no plans for his discharge.

We waited 2 hours for his medication to then find it was on a desk, on the ward. The staff just hadn't checked. We had to find a wheelchair ourselves to help him to exit the hospital and incurred car park charges due to the delay with the meds that were waiting for us.
Staff were busy, so it's hard to blame them, but the discharge felt shambolic."

"My Husband was discharged to the discharge lounge at 11.30am. and we did not get his medication until 6.30 pm. When we arrived at the hospital nobody seemed to know where he was as the discharge nurse finished her shift at 1.30pm. He was put into ward 221 and was sat by a bed occupied by another patient with his belongings and forgotten about until we arrived and a receptionist hunted him down. I cannot understand why a prescription could not have been issued and we could have filled it at our local pharmacy. 7 hours waiting for medication is unacceptable."

22. On the day of discharge was the patient given a contact number of who to call if they had any concerns?

Answer Choices		Response Percent	Response Total
1	Yes	27.50%	44
2	No	58.13%	93
3	Not sure	14.38%	23
		answered	160
		skipped	11

23. On the discharge care plan, how understandable was the information the patient received about the care that would be provided and when?

Answer Choices		Response Percent	Response Total
1	Very understandable	18.75%	30
2	Somewhat understandable	31.25%	50
3	Not very clear	12.50%	20
4	Difficult to understand	3.75%	6
5	Not sure or not applicable	33.75%	54
		answered	160
		skipped	11

24. What time of day/night was the patient discharged from hospital?

	Answer Choices	Response Percent	Response Total
1	Between 9am and 1pm	12.50%	20
2	Between 1pm and 5pm	54.38%	87
3	Between 5pm and 11pm	31.25%	50
4	Between 11pm and 9am	1.88%	3
		answered	160
		skipped	11

25. How did the patient return home?

	Answer Choices	Response Percent	Response Total
1	Patient Transport or Ambulance	36.65%	59
2	Collected by family member	52.17%	84
3	Taxi	4.35%	7
4	Public Transport	0.00%	0
5	Other (please specify):	6.83%	11
		answered	161
		skipped	10

26. How do you rate the patient's discharge from hospital and how it was planned and coordinated?

	Answer Choices	Response Percent	Response Total
1	Poor	33.13%	53
2	Fair	25.63%	41
3	Good	28.75%	46
4	Very Good	6.88%	11
5	Excellent	5.63%	9
		answered	160
		skipped	11

See Question 32 for a combined response.

Section 6: The Patient's Experience After Discharge

27. When the patient arrived home was the residence suitable to return to (e.g. heating turned on, basic provisions provided, equipment in place)

	Answer Choices	Response Percent	Response Total
1	Yes	79.87%	123
2	No	13.64%	21
3	Not sure	6.49%	10
		answered	154
		skipped	17

28. Were all the services the patient was expecting to receive (as outlined in the care plan) in place or provided when expected?

	Answer Choices	Response Percent	Response Total
1	Yes	54.17%	78
2	No	26.39%	38
3	Not sure	19.44%	28
		answered	144
		skipped	27

29. Do the services the patient is receiving meet their current needs?

	Answer Choices	Response Percent	Response Total
1	Yes	69.23%	99
2	No	17.48%	25
3	Not sure	13.29%	19
		answered	143
		skipped	28

Questions 27, 28 and 29, elicited similar responses and sentiments. About 80% of patients returned to a warm home with adequate provisions.

26% of those who responded said that the planned services were not in place or provided on their return, but around 70% of patients are currently receiving the services that they need to meet their current needs. In some cases, services are

not always provided according to the care plan and sometimes there is no care plan.

"Still do not have a care plan. My father has been on a D2A pathway since 3rd Oct 2024 - today is 18th Dec 2024"

"Only because the family took responsibility. Nothing to do with the discharge process which was poor. Suitable services were only put in place "much further down the line".

It is clear from the survey that most patients rely heavily on family to support them when returning home after discharge. This may be partners or family that they already live with, or their wider family.

Where care packages had previously been in place, these seemed to be reinstated quite effectively in most cases.

- "Care plan reinstated with extra care for a short time"
- "Care package restarted"
- "Care started again the following day"
- "Carers came next day as planned."

Some new care packages were started effectively, while some were subject to delays, which caused anxiety for patients and their families. At times carers and/or nurses did not arrive as promised. It would be helpful for future care, for patients under Home First to be reviewed proactively in case there are longer term needs. District Nurses were well thought of.

"I was told that carers would come in 4x a day but following day no-one arrived daughter had to chase up with hospital"

"We were promised that the Ward would be in touch for an update on the patient's condition, also promised a visit from the District Nurse (DN) on the following day - no show from either. The DN did visit on day 2 of discharge but there has been no contact from the Ward."

"Palliative care package not initiated in time."

"Home adjustments didn't happen until the following days. NHS carers had to visit multiple times a day until adjustments were in place."

"Carers didn't visit as scheduled, and calls were made multiple times when they had not turned up."

"No services for several days, was discharged on Discharge to Assess"

"I did not see a care plan but was given a Nurse-to-Nurse communication Form advising that the District Nurse would visit following day - which did not happen. Was also given details for open access to SAU and SSDEC."

There was also some very positive feedback about care planning:

"District Nurse came daily to check wound."

"The District Nurse Service has been brilliant, very kind, caring and professional."

"The following day received carers for 2 weeks until better. Nurses and carers visited every day"

"Services arranged by discharge team were great. Times were arranged with myself and happened at the prearranged Time."

"Home First were brilliant but no other care after 6 weeks, so my nan relied on family. At 4 weeks it would have been beneficial to have a support worker or social worker to visit my nan to see if there was any further support that could be placed"

"I had a discharge plan for 6 weeks of care to help me recover from my operation"

30. Do you know who to contact if you need any change in your services?				
Answer Choices			**Response Percent**	**Response Total**
1	Yes		56.76%	84
2	No		27.70%	41
3	Not sure		15.54%	23
			answered	148
			skipped	23

31. Were you or the patient readmitted?				
Answer Choices			**Response Percent**	**Response Total**
1	No		78.91%	116
2	Yes, within one day		4.08%	6
3	Yes, after 2 or 3 days		5.44%	8
4	Yes, after 4 to 7 days		11.56%	17
			answered	147
			skipped	24

There were six reports of readmission within 24 hours. Two patients were readmitted following falls at home, three reported as premature discharges and one readmitted from the discharge lounge due to a placement delay.

Eight readmissions after 2-3 days were reported. The majority were related to post surgical issues including wound care and infections.

Seventeen readmissions were reported after 4-7 days. The reasons included:

- Post Surgery infections - 3
- Adverse reactions to medication changes - 3
- Catheter management issue - 1
- Breathing issue - 1
- Original condition - 3

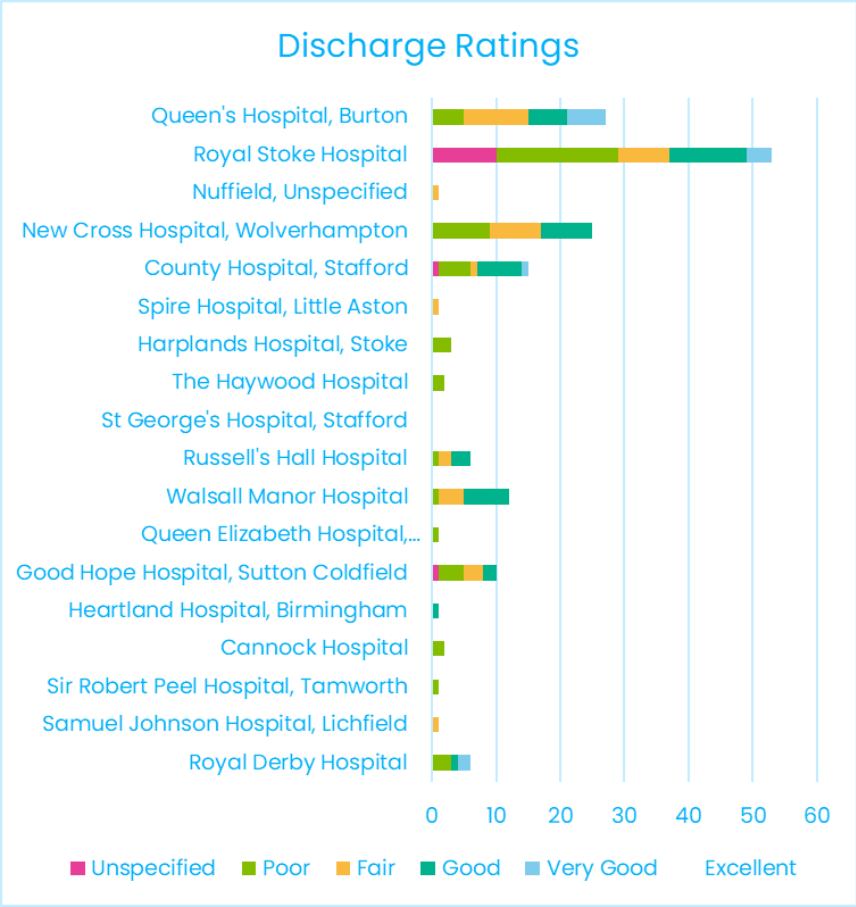
Any Other Information - Themes

32. Is there any other information you would like to share with us about your experience of hospital discharge			
Answer Choices		**Response Percent**	**Response Total**
1	Open-Ended Question	100.00%	84
		answered	84
		skipped	87

Questions 26 and 32 elicited 247 responses, many of which can be grouped under the following themes:

- Communication
- Discharge Planning
- Delays in Discharge
- Choice and Control.

The table below shows the overall ratings of hospitals patients and families referred to in the survey.



Communication

Whilst there was some positive feedback indicating good communication, we've heard about the impact of poor communication both with patients and their families. This includes family members and carers not getting prior notice of discharge or not being involved in conversations about the support available at home.

Overall, 59% of people rated their discharge experience as fair or poor and many of those told us they were dissatisfied with how they'd been kept involved in conversations around discharge.

Positive Feedback

"Discharge process clearly explained - and next steps including information about follow up appointments was discussed. On the day of discharge both the Senior Sister on CCU and the consultant went above and beyond to make sure all the relevant test results were back and reviewed to enable my discharge - and all my medication was ready. Discharge was clearly explained, and I was given a contact number for the ward if I had any concerns or queries. The treatment and care I received at Queen's Hospital was excellent"

"Yes. That was done clearly. Everything was clear and well explained by the nurses and doctors that checked me. Tests were done and I was told what the problem was. I was happy overall. "

Neutral and Negative Feedback

"They were going to send my mother home without a care plan in place. On the day of her discharge, I visited her on Ward 9 (I was unaware she was being discharged). I went on the ward, went to her bed, she wasn't there. They then showed me to a different bed with a lady in it, who I didn't know. When I questioned again where my mother was, they then told me she was in the discharge lounge.

I went to the discharge lounge and asked questions about my mother's discharge, they told me she was fit to be sent home. I explained that she needed a care package. They then put her discharge on hold, whilst a

care package was sorted. As often is the case with health services, poor communication was at the heart of her poor care".

"Poor, lack of communication, not involved in process, was put with Home First, despite having a care provider who was the preferred care provider, who had kept capacity slot for the person to return. Disjointed, poor discharge, unsafe, and was readmitted".

"They did not take into consideration the patient's poor memory or risk of seizures. No communication with family or unpaid carer."

"Poor communication, missing medication, no follow up appointment"

"I was discharged from Cannock Hospital and I was not informed except told 'you are being sent home today'. Nobody advised me approximately what time and when the crew arrived nobody came to assist"

"Just told I was leaving hospital on the day before. No discussion no nothing. Not very good at all".

Discharge Planning

NHS guidance on hospital discharge* states that the NHS should support patients and their relatives and carers in making fully informed decisions about the care and support they receive on discharge from a hospital, where appropriate.

*https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance

There were some positive comments made about discharge planning and where it worked well, patients and families were complimentary:

Three patients praised the "excellent treatment and care."

Others highlighted the "excellent district nursing team," praise for "Dawn and the Discharge team," "overall reasonably good service," "amazing palliative care," and "very friendly and helpful staff."

On occasions the system appears to be failing badly; One concerned neighbour wrote about their elderly and vulnerable neighbour who lived alone and was returned home by patient transport in the evening. He had physical health conditions (respiratory and cardiovascular) and mental health problems, including dementia. The neighbour reported that the discharge was:

"Appalling, sent home with nothing and just dropped off at home with nothing, Good job neighbours saw what happened and intervened to make sure he had some heating and food to be going on with." They continued: "Social services are shocking they won't accept any information from neighbours who are just trying to help"

There can be poor hospital communication with the patient's family and with other services. Another vulnerable lady with dementia, cardiovascular problems and poor mobility was discharged home in the evening by patient transport. Her family reported:

"Nothing done due to lack of notice and lack of communication with family. Shocking". Going forward she is "Still relying heavily on family who work full time. No help forthcoming from social services or anyone else in the health system".

People have told us about not being involved in discharge planning and the inappropriate discharge of patients where an assessment of needs or provision of services, such as care packages, was not made in a timely manner, or had not been arranged at all.

"Patient with dementia and mental health was discharged from hospital with no support and no assessment of physical needs. Sent home with nothing. Miscommunication between ward and social services"

"Whilst waiting on the ward to find out if I was leaving (which I had been told would happen the evening before), I had to keep calling the staff to find out what was happening as I was receiving no information. The staff seemed to have forgotten about me".

"My husband was diagnosed as needing palliative care and arrangements were to be put in place for care at home and were told by

the ward staff that this would take 3-5 days. An Ambulance brought him home the following day without any services or equipment in place as primary care were not contacted initially. Took three days for a palliative care package to be put in place".

Delays in Discharge

The responses given to Question 21 of the survey clearly outline the sense of frustration and annoyance at having to wait, sometimes for many hours. Patients are left on a ward or in the discharge lounge, waiting for medication or transport and having no indication of how long these waits may be. A closer alignment of the availability of medication/ transport and being informed of an approximate discharge time would go some way to alleviating these delays.

We were told that the provision of aids and adaptations can also cause delays. These are not always considered at the point of discharge and the public don't know who they can contact once they return home to discuss their options. People told us that whilst personal care and basic medical provisions were in place, there was no discussion around things like key safes, pendants, and bathroom aids.

This raises the issue about a holistic approach to discharge planning and involving voluntary services who can provide a range of services to support hospital discharge.

Choice and Control

We were told by some patients and families that when they/their relative needed to be discharged to a D2A bed, they had little or no say as to where that bed would be. This was a particular issue for people living on the borders of Staffordshire who received their treatment in a cross-border hospital. They could be allocated a bed many miles from their home, making it very difficult for them to receive visits from family members.

The main issue reported was that they were not consulted or included in discussions about where they would go and not given any alternative options such as placement in local care homes where relatives could at least visit. In many cases this had a detrimental impact on the health and mental well-being of both patients and families.

Follow up well-being checks after discharge was an area that was raised as being beneficial to patients. One patient who had experienced a life-changing illness spoke about feeling overwhelmed and abandoned having been discharged without any support to manage the transition home after a lengthy stay in hospital.

"Transferred to a community hospital in Tamworth to await homecare package being organised. It is a long way from where I live and for my relatives to visit"

"Sent to various hospitals all over Staffordshire including County and Robert Peel despite living in Wombourne. It was appalling. No say in the matter and no consideration about relatives visiting"

Conclusions and Recommendations

Conclusions

The experiences of patients and carers that we've collected during this project show that there is a lot of good positive practice around hospital discharge. This was evidenced by the fact that 42% of survey respondents rated their discharge as either good, very good or excellent. However, 50% of respondents rated their experience as either fair or poor. This demonstrates that there is room for improvements to be made for patients being discharged from hospital particularly in the areas outlined in the findings, namely communication, discharge planning, delays in discharge and choice and control.

The Hospital Discharge and Community Support guidance issued by the Department of Health in January 2024 emphasises:

Planning for discharge should begin on admission. This will enable the person and their family members or unpaid carers to ask questions, explore choices and receive timely information to make informed choices about the discharge pathway that best meets the person's needs. Involving patients, families and carers is a key component of a good discharge and one less likely to lead to poor or failed discharge.

Hospital discharge and community support guidance - GOV.UK

Communication is a key facet of effective discharge planning and as this study shows it is a critical component in the discharge process. This is evidenced by the number of respondents who cited poor communication and inadequate collaboration during the discharge process as the main contributory factor in their perception of discharge as a poor experience.

Recommendations

- All partners involved in the hospital discharge process should review their discharge information, policies and procedures to check that they involve both people staying in hospital and their family and/or carers, where appropriate, at key points.
- All patients should be involved in and informed of their discharge plan, including any services they can anticipate receiving, including services that may be offered by other professional such as Primary and Community Services and Social Care. Hospital staff should check that patients are able to understand the information and if necessary, involve families and carers in the process. We would suggest that this conversation should be undertaken soon after admission to avoid patients feeling unprepared for discharge.
- Review and revise methods of communication with both patients and family/carers and include all those involved in the discharge of patients, in order to better integrate care and to minimise confusions or unnecessary delays during discharge.
- Devise a system to monitor the quality of hospital discharge. Upon discharge, patients, family members and carers should be given opportunities to feedback on how they felt the service worked for them. What was good and what could be improved. The responses from this should be used to improve practice for patients and families on an on-going basis.
- The commissioning of D2A beds for patients living on the borders of Staffordshire should be as close as possible to the area where patients usually live, to eliminate excessive and restrictive travel demands placed on those visiting patients during their stay.
- Ensure that patients and families or carers are involved in the D2A process, so that discharge discussions are not handled at the last minute
- Medication delays was a significant factor in patients leaving hospital. We suggest a review of discharge processes to ensure clearer alignment between the discharge and the delivery of medicines required, including the provision of a prescription that could be filled at their local pharmacy where appropriate. This would improve the experience of discharging patients in a timely manner.
- All patients, before leaving the hospital, should be informed verbally and in a written document of ways to contact the hospital post-discharge, whenever the need arises. This was not done consistently.
- Consider putting in place a system of well-being checks post discharge for those patients who may have had lengthy stays in hospital and who may not be in receipt of a care package to support the discharge.

Appendix 1

Section 7 - Demographics

33. Please tell us their age				
Answer Choices			**Response Percent**	**Response Total**
1	0 to 12 years		0.00%	0
2	13 to 15 years		0.00%	0
3	16 - 17 years		0.00%	0
4	18 - 24 years		0.68%	1
5	25 - 49 years		5.48%	8
6	50 - 64 years		9.59%	14
7	65 to 79 years		29.45%	43
8	80+ years		52.05%	76
9	Prefer not to say		0.00%	0
10	Not known		2.74%	4
			answered	146
			skipped	25

34. Please tell us their gender				
Answer Choices			**Response Percent**	**Response Total**
1	Woman		51.70%	76
2	Man		44.90%	66
3	Non-binary		0.00%	0
4	Prefer not to say		2.72%	4
5	Prefer to self describe:		0.68%	1
			answered	147
			skipped	24

35. Please select their ethnicity				
Answer Choices			**Response Percent**	**Response Total**
1	Arab		0.00%	0
2	Asian/Asian British: Bangladeshi		0.00%	0
3	Asian/Asian British: Chinese		0.00%	0
4	Asian/Asian British: Indian		0.00%	0
5	Asian/Asian British: Pakistani		0.00%	0
6	Asian/Asian British: Any other Asian/Asian British background		0.00%	0
7	Black/Black British: African		0.00%	0
8	Black/Black British: Caribbean		0.00%	0
9	Black/Black British: Any other Black/Black British background		2.00%	3
10	Mixed/multiple ethnic groups: Asian and White		0.67%	1
11	Mixed/multiple ethnic groups: Black African and White		0.00%	0
12	Mixed/multiple ethnic groups: Black Caribbean and White		1.33%	2
13	Mixed/multiple ethnic groups: Any other Mixed/Multiple ethnic group background		0.67%	1
14	White: British/English/Northern Irish/Scottish/Welsh		88.00%	132
15	White: Irish		2.00%	3
16	White: Gypsy, Traveller or Irish Traveller		0.00%	0
17	White: Roma		0.00%	0
18	White: Any other White background		2.00%	3
19	Prefer not to say		3.33%	5
20	Other (please specify):		0.00%	0
			answered	150
			skipped	21

36. Please select any of the following that apply to them (you may choose more than 1)				
Answer Choices			**Response Percent**	**Response Total**
1	They have a disability		37.59%	53
2	They have a long-term health condition		75.89%	107
3	They are a carer		4.26%	6
4	None of the above		9.22%	13
5	Prefer not to say		5.67%	8
			answered	141
			skipped	30

37. Which of the following disabilities or long term health condition do they have?				
Answer Choices			**Response Percent**	**Response Total**
1	A physical or mobility impairment		47.83%	66
2	Deaf or hearing impaired		18.84%	26
3	Blind or sight impairment		8.70%	12
4	Learning disability		0.72%	1
5	Mental health condition		4.35%	6
6	Asthma, COPD or respiratory condition		15.94%	22
7	Cancer		8.70%	12
8	Cardiovascular condition		33.33%	46
9	Chronic kidney disease		11.59%	16
10	Dementia		10.14%	14
11	Epilepsy		1.45%	2
12	Diabetes		18.12%	25
13	High blood pressure		15.94%	22
14	Prefer not to say		7.25%	10
15	Other (please specify):		14.49%	20
			answered	138
			skipped	33

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End of Report

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