healthwatch Cheshire West

Discharge from Hospital

Phase 2: Post-Discharge

September 2026

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Executive Summary

This report is the second phase of Healthwatch Cheshire West's *Discharge from Hospital* project. Phase 1 captured what patients experienced while still in hospital, at the point their discharge was being discussed or finalised. Phase 2 follows those same patients from the moment they left Leighton Hospital through to how they were settling in at home or in a care setting weeks later.

Between December 2025 and July 2026, Healthwatch contacted the 26 Cheshire West and Chester residents who had taken part in Phase 1. Fourteen agreed to a follow-up interview. Three patients were back in hospital when we made contact: two had been re-admitted, and one had discharged herself from her care setting to a relative's home, where she fell and was admitted. One patient had moved to end-of-life care, and eight could not be reached. Of the 14 interviewed, eight had been discharged directly home and six to a care setting. Three of those six moved on during the project – two to their own homes and one to a friend's house – giving a picture of the journey through all three routes.

What we found

What happened once patients left the hospital varied widely. The day of discharge itself mostly went well. Ten of the 14 patients felt the timing was right, 12 of the 14 left with sufficient medication, and the ambulance, Red Cross and hospital transport crews were widely praised. The waiting was more challenging: patients described staying overnight and for multiple days in the discharge lounge, and when there were delays, they usually had to ask for the reason. Twelve of the 14 described their discharge overall as safe and positive, a verdict on the decision to move them on rather than on how it was carried out.

The area that most consistently created difficulties for patients was the information that should have travelled with them. Nine of the 14 had no designated point of contact after discharge – no number to call if something went wrong. Three discharge letters were missing, contradictory or incomplete: one GP did not know their patient had had a stroke, and a relative had to call NHS 111 to keep essential medication going. Two patients had problems with their insulin – a pen supplied without needles, and injections switched to tablets without discussion.

Among those who went directly home, most were well supported. Eight of the 11 patients at home rated their care as very good; families were closely involved in most cases, and two patients recovered well enough to end their care packages early. One discharge stood apart: a patient admitted from a 24-hour care facility was sent home with four daily visits and no one with her at night. Her family was told that funding for a care placement was not available; they felt 'she had simply been sent home to die.'

Among those who went to care settings, most described the move as accepted or chosen rather than imposed, and all six said the step had helped their recovery. The first hours were when things went wrong: one patient waited four and a half hours for pain relief, and another was left in a lounge until 8pm

before anyone explained what was happening. Rehabilitation was purposeful where it existed and simply absent where it did not. One planned return home from a care setting failed on the day it was attempted, because the house was not ready; twelve weeks after leaving hospital, that patient remained in the care home, paying privately.

Across all routes, two threads ran through the findings: families carried much of the coordination and caught most of the errors, and money shaped several journeys – a surprise care contribution, a ten-week physiotherapy wait weighed against paying privately, and two self-funded care home beds.

- **14** patients interviewed for Phase 2
- **9/14** had NO designated point of contact after discharge
- **12/14** transferred with sufficient medication
- **3/14** discharge letters were missing, contradictory or incomplete

This report is intended to be read alongside Phase 1 and will form part of the evidence for the final *Discharge from Hospital* report, which will bring together findings from all phases and make recommendations.

These findings land as the NHS 10 Year Plan shifts more care into neighbourhoods. The gaps described here – contacts, letters, handovers between organisations – are exactly the connections that neighbourhood-based care will depend on.

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. 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 Hospital, 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 the number of patients is known and regularly reported on, the experiences of people are often not captured. Appendix 1 contains fuller notes taken during 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

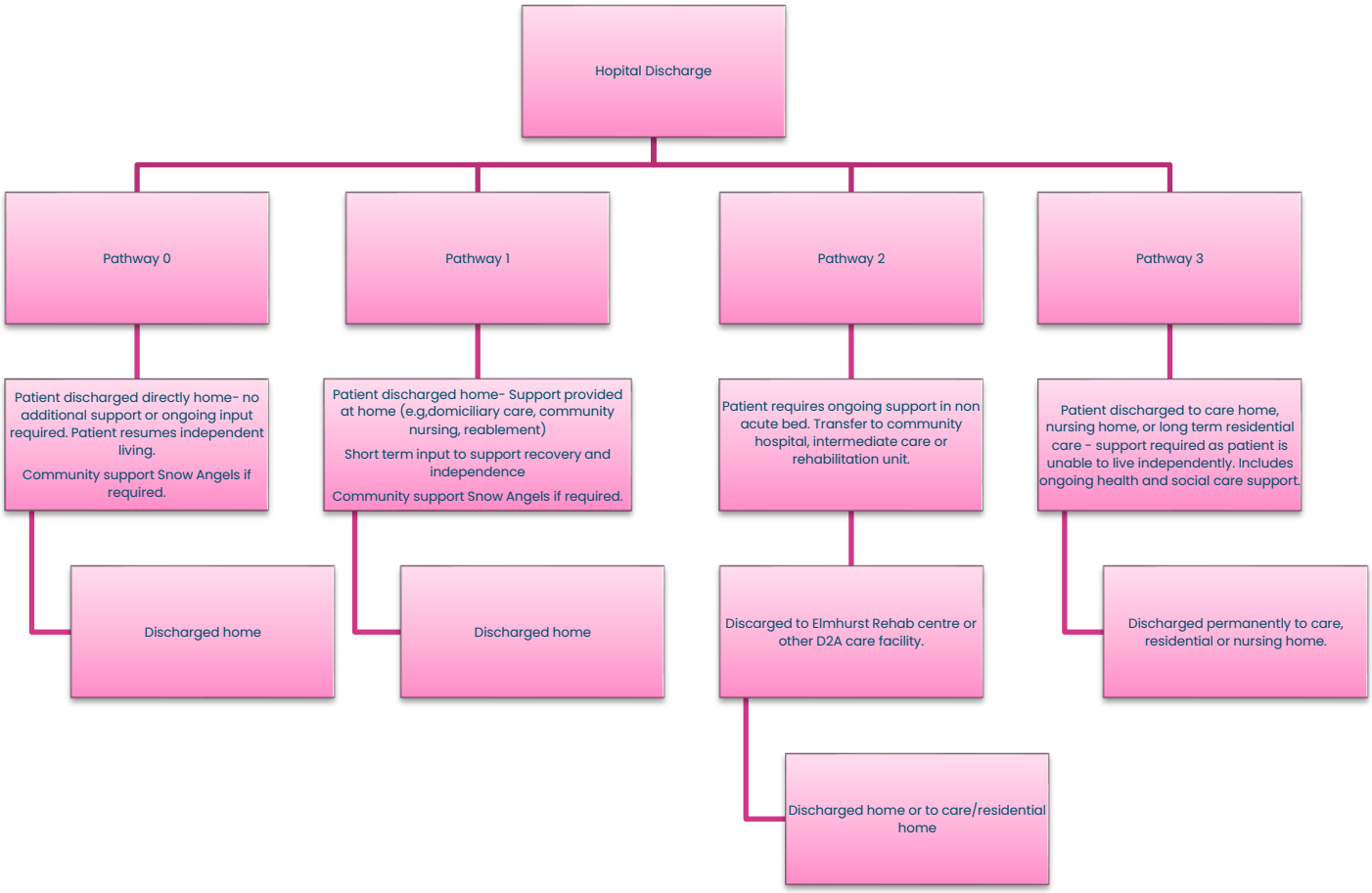
This report focuses on the post-discharge experience of Cheshire West and Chester residents who took part in Phase 1 at Leighton Hospital. It follows patients through three distinct journeys:

- Those discharged directly home
- Those discharged to a care setting
- Those who moved from a care setting back into a home

For this group, discharge crosses an organisational boundary. Leighton Hospital, in Crewe, is run by Mid Cheshire Hospitals NHS Foundation Trust and sits in Cheshire East. The patients in this report live in Cheshire West and Chester,

where the support that follows them home — care packages, district nursing and adult social care — is based. The discharge pathways are the same, but the organisations behind them change at the border, and some of the experiences described in this report sit at that join.

The chart below is a snapshot of how the discharge process works.



The findings from this report will be shared with Mid Cheshire NHS Foundation Trust, Cheshire West and Chester Council, Central Cheshire Integrated Care Partnership (CCICP) and Cheshire and Merseyside Integrated Care Board, and published on Healthwatch Cheshire's websites. They will feed into the final *Discharge from Hospital* report, which will bring together findings from all phases and include recommendations.

Healthwatch would like to thank the Cheshire West and Chester residents who took part in Phase 1 and agreed to be contacted again as part of this project. Fourteen gave their time to a follow-up interview, and in some cases family members took part alongside them, adding detail the patient could not always give. Their willingness to continue sharing experiences – often at a personal and difficult time – is what makes this project possible.

Methodology

How Healthwatch carried out this work

Phase 2 of the *Discharge from Hospital* project involved following up the Cheshire West and Chester residents who had taken part in Phase 1 at Leighton Hospital. The data processing agreement with Mid Cheshire NHS Foundation Trust, established at the outset of the project, remained in place throughout Phase 2 and covered the follow-up contact process.

During Phase 1, patients were informed that Healthwatch would contact them again after their discharge. Those who agreed to take part in a follow-up gave their consent at that stage, and contact details were recorded at the time of the Phase 1 interview.

Patients receiving support after discharge described several separate services, which are referred to in this report by their commonly used names. These include reablement (short-term care to help people regain independence after leaving hospital); IPOCH (the Integrated Placement of Care Hub, a discharge and support team based at Leighton Hospital); district nursing; and commissioned domiciliary care agencies. "Care package" refers to the arranged carer visits. Two patients lived in assisted living schemes with their own on-site care teams; for one of them, reablement worked alongside that team before handing back to it.

For this group, these services sit either side of a boundary. Leighton Hospital and its discharge teams are part of Mid Cheshire Hospitals NHS Foundation Trust, in Cheshire East. The patients live in Cheshire West and Chester, so adult social care, social work involvement and financial assessments for care sit with Cheshire West and Chester Council. One patient's short rehabilitation stay was at Elmhurst Intermediate Care Centre in Winsford, which is run by the Trust; the other care settings were residential and nursing homes. Two patients funded their own placements, and their arrangements sat outside council-arranged care.

How patients were contacted

Healthwatch attempted to contact all 26 patients from Phase 1. Initial contact was made by telephone. Where a patient preferred, or where their circumstances made it more appropriate, a follow-up interview was arranged in person – at their home, at the home of the relative or friend they were staying with, or at the care setting they had moved to. In some cases, a family member took part alongside the patient, and their contributions are reflected in the findings.

Of the 26 patients contacted:

- Two had been readmitted to hospital and could not take part
- One had discharged herself from the care setting to a relative's home, where she fell and was admitted to hospital

- One had moved to end-of-life care following their discharge and did not continue to the next stage
- Eight could not be reached
- Fourteen, who agreed to a follow-up interview, form the basis of this report

When the interviews took place

Phase 2 interviews took place between 2 December 2025 and 28 May 2026, at varying points after each patient's original discharge date. Where a patient's journey continued — from a care setting back into a home — Healthwatch visited again, and these further visits ran into early July 2026.

The question set

The Phase 2 question set used the same semi-structured format as Phase 1. Because patients had been discharged to different settings, the questions followed a branching structure from Q41 onwards (Appendix 2):

- All 14 patients answered questions covering the day of discharge (Q25–Q40)
- Patients discharged directly home answered the home-based question set (Q60–Q75)
- Patients discharged to a care setting answered questions covering that experience (Q42–Q54). Three of those six patients subsequently moved on into a home and also answered Q55–Q75

Where in-person interviews took place

In-person interviews took place at patients' homes, at the friend's home one patient had moved to, and at the care settings patients were staying in. The care settings involved in Phase 2 were Clarendon Court Care Home in Nantwich, Elmhurst Intermediate Care Centre in Winsford, Iddenshall Hall Care Home in Tarporley, Redwalls Nursing Home in Sandiway, and Overdene in Winsford. One interview was conducted by telephone.

Who took part and what the findings are based on

Findings draw on 14 interviews, combining closed-question responses with notes taken during each conversation, consistent with the approach used in Phase 1. All comments are anonymised. The patient stories in this report are labelled with a letter (Patient A, Patient C, and so on). The same letters are used in the interview notes at Appendix 1, so any story can be read in full there. The letters run A to Z across all 26 patients who took part in Phase 1, which is why the letters used here are not consecutive.

Section	Questions	Who	n
Day of discharge	Q25–Q40	All Phase 2 participants	14

Care setting experience	Q42–Q54	Patients in a care setting	6
Home experience	Q60–Q75	Patients at home (8 discharged directly, 3 via a care setting)	11

Findings

Of the 26 Cheshire West and Chester residents who took part in Phase 1, 14 agreed to a Phase 2 interview. Eight were discharged directly home. Six were discharged to a care setting, and three of those six moved on during the project: two to their own homes, and one to a friend's house.

Of the remaining 12, three were back in hospital by the time Healthwatch made contact. Two had been readmitted, and one had discharged herself from her care setting to a relative's home, where she fell and was admitted. One patient had moved to end-of-life care. Eight could not be reached.

The findings are organised around where patients went after leaving hospital. We begin with the day of discharge, which every patient shared, before following three routes: directly home, to a care setting, and from a care setting back into a home. One feature of this group is worth naming at the outset: "home" did not always mean the patient's own home. One patient went to her parents' house because her own could not yet support safe rehabilitation. Another moved to a friend's house while she regained the strength to manage her own. In both cases, the road home ran through someone else's front door.

The day of discharge

Phase 1 ended as patients were preparing to leave Leighton Hospital. This section picks up from there – what the actual day of discharge was like, from waiting to leave through to arriving at their destination. It covers all 14 patients, regardless of where they went.

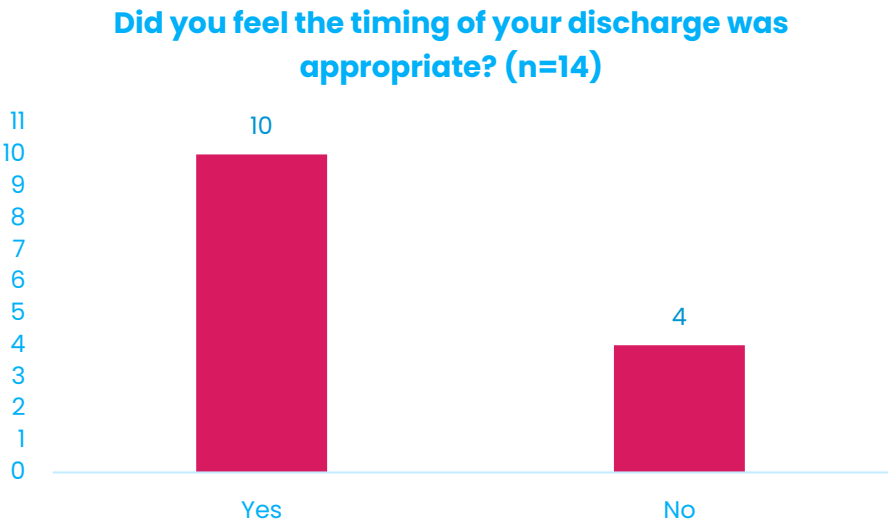
Timing and waiting

Ten of the 14 patients felt the timing of their discharge was appropriate. The four who did not, were not questioning the decision to send them on; they were describing the wait and the silence around it. One was moved to the discharge lounge the night before and left hospital late the following afternoon. One spent 24 hours in the lounge: "no windows, nothing to do, with no television near me." One was ready at 10am and left at 4pm, after transport was rebooked due to medication that was not ready. One knew she was leaving that day but was never told who was collecting her, or when.

Waits ranged from a couple of hours to around three days. The longest was for a care package to be arranged; once it was in place, that patient said, everything moved fast. Another patient spent two days in the discharge lounge. Phase 1

described people waiting overnight in the lounge, with no natural light and little to do. Phase 2 shows the same pattern.

Where there were delays, the reason usually had to be asked for. One patient was told upfront why she was waiting. Two found out only by asking the staff. One was told the reason for her first delay but not her second. One had raised it during her Phase 1 interview; with her permission, our staff member asked the ward sister to update her, but no one ever came back to tell her.



Transport

Seven patients travelled by ambulance, four with the British Red Cross, two by a relative's car and one with the hospital transport service. The crews were widely praised. One patient said he couldn't fault the hospital transport at all. Another described her Red Cross volunteers as very good and the journey as pleasant and manageable. A third called the Red Cross "brilliant." One ambulance crew, learning their patient had spent 24 hours in a windowless lounge, drove the scenic route home so she could see the daffodils and the spring countryside she had missed from the ward.

Two journeys stand apart, for different reasons. In one, the crew was kind but had not been told the patient could not walk and needed to travel by wheelchair; it took 30 minutes of reassurance to get a frightened patient from the vehicle into her own house. In the other, a paramedic's conduct left the patient in tears before she had left the ward. Her account is in the patient stories for the day of discharge.

Medication and discharge letters

12 of the 14 patients left hospital with sufficient medication. Of the two who did not, one was sent home with her insulin pen but the pen had no needle in it and none had been sent, so no insulin was actually reaching her. Her family only discovered this once she was home. The other had her anti-sickness medication

stopped at discharge although she still needed it; she arrived at her care home feeling sick and did not want to eat for her first few days.

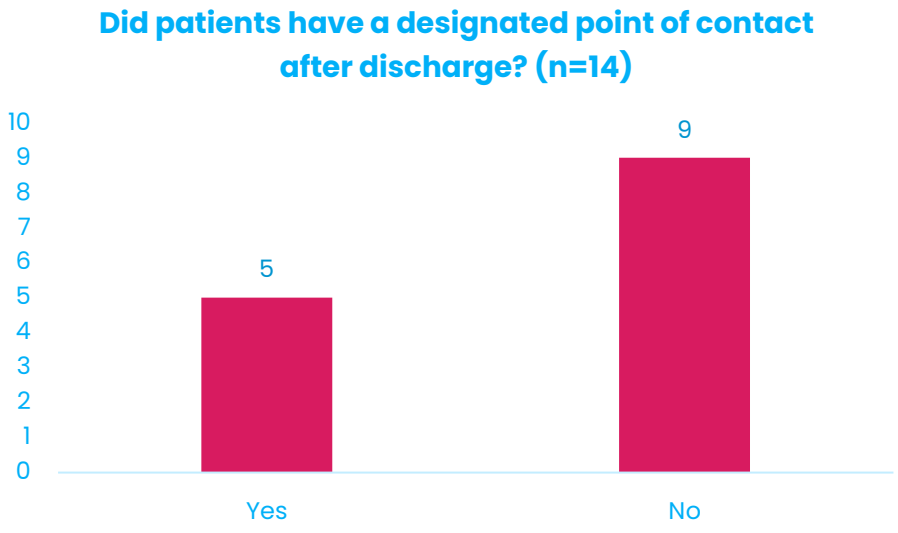
A separate problem was not about supply but about what happened next. One patient reached her care home to find her medication had not been recorded there, and waited more than four hours in pain before it was resolved; her account is in the patient stories for hospital to care setting. A further problem surfaced at home: one patient found he had been switched from insulin injections to tablets without discussion. The tablets did not work as well for him, and it was about a week before his daughter spotted the problem and arranged a return to his usual injections through his GP. He counts that week as lost from his recovery.

The paperwork travelled less reliably than the medicine. One patient left with no discharge letter at all. Her GP had no notes and did not know she had had a stroke. She could not order repeat prescriptions, a relative called NHS 111 for emergency insulin and blood thinners, and the paperwork was completed in the third week after discharge. Another patient's discharge letter was produced twice, with contradictory instructions about the same medication. A third letter made no mention of the patient's anaemia or any follow-up plan for it. Three of the 14 discharge letters, in other words, were missing, contradictory or incomplete.

- 12/14 were transferred with sufficient medication
- 12/14 had something to eat before leaving hospital

Point of contact after discharge

9 of the 14 patients had no designated point of contact after leaving hospital. Only two left with something written down: one had telephone numbers for both the care team and the hospital, and one had the IPOCH team's number written on a leaflet. Among the others who answered yes, the contact was something they had supplied themselves: a ward they knew from a previous discharge, the staff of the care home they were heading to, or a daughter. One patient was given a hospital telephone number weeks later, by a consultant at a follow-up appointment. Phase 1 found that people often lacked a consistent person to talk



to while still on the ward. Phase 2 suggests the gap follows them out of the building.

Overall sense of safety

12 of the 14 patients felt their discharge had been safe and positive. The question asked them about the decision to move them on, not the way it was carried out, and it was answered that way. One said yes and then described it as "[a] bag on the bed and you're going home today." Another said yes and added that the only thing not positive was the delay. So did the patient who left with no discharge letter at all. For one patient now in a care home, safe was precisely the word: "it was the safe decision, it wasn't safe for me to go home."

Two patients said no. One had been admitted from a 24-hour care facility and was sent home to four daily care visits, with no one there at night; her story is told in the next section. The other described her discharge as "absolutely horrendous," again for reasons that had nothing to do with the decision itself. What patients objected to was rarely being discharged, and almost always what happened around it.

What patients told us: the day of discharge

When the ambulance crew arrived, one patient had not finished packing. Her leg operation and knee replacement meant she could not manage it without help, and she was still waiting for a nurse's email address she needed for a travel insurance claim. One paramedic came in and said, loudly, "why aren't you ready, get your stuff together," then complained about her bags: "we can't possibly carry all this stuff. The handles are cutting into my hands." She was in shock and started to cry. The ward sister stepped in and sent an assistant to help pack. The second paramedic sat with her in the back of the ambulance and chatted kindly all the way. At the care home, the other patient sharing the vehicle was turned away because the home could not meet their needs, and was taken back to the hospital. The patient asked Healthwatch to pass her experience on through our feedback centre so she could draw a line under it and focus on recovering. (Patient Z)

One patient waited in the discharge lounge from one afternoon to the next: no windows, nothing to do, no television near her. When her ambulance came, about 4.30pm the following day, the crew took the scenic route so she could see the daffodils. (Patient U)

One patient was told the wait was for transport only when she asked. She also learned, by asking, that her original care home had been changed because of an infection outbreak. When she left, the hospital was meant to phone her next of kin; it phoned her second daughter instead. (Patient L)

One patient's transport arrived in the morning, but her medication was not ready. It was rebooked for 1pm and came at 4pm, with no reason given. Expecting to leave, she had not ordered meals; the lunch she was brought was unsuitable, so staff found her another, which she enjoyed. (Patient Y)

One patient spent two days waiting in the discharge lounge. When the day came, he was discharged at 10.30am and his daughter collected him at 10.40am, exactly as arranged the day before. The leaving took ten minutes. The waiting took two days. (Patient K)

One patient described a discharge that was smooth, well co-ordinated and efficient, with the ambulance waiting at the door and her daughter fully informed throughout. (Patient N)

1. Hospital to home

8 patients discharged directly home

Eight of the 14 patients went straight from Leighton into a home: seven to their own, one to her parents' house while her own was made ready. All eight left with support in place. Most had a care package of two to four visits a day, two had reablement care (short-term support to help people regain independence), several had district nurses, and everyone had family close by.

The "home" questions in this section were answered by all 11 patients who were at home at the time of their interview, including the three who returned home from a care setting and are covered in section 3. Figures below reflect that group of 11. The stories are those of the eight who went straight home.

First days at home

For most patients, their immediate needs were generally met in the first days after discharge. All 11 patients at home had adequate food and support on arrival, provided by family members, friends, or the assisted living scheme where they lived. The formal system's part had rough edges. One patient's first follow-up call did not come until 9pm on the day he got home. Another arrived home near lunchtime, and carers were not due until 4pm. Nobody at the hospital had asked whether anyone would be there to make her lunch.

In Phase 1, 24 of the 26 patients said they felt prepared to leave hospital. For most of this group, that confidence held once they were home. For one family, it did not; their account is told in full in the patient stories for hospital to home.

Care packages and reablement

All 11 patients at home had community services supporting them. All but one patient said the support at home was sufficient to manage their daily activities and recovery; hers was the exception. The packages themselves varied more.

The strongest examples were described in notably positive terms. One patient called his reablement carers "absolutely fantastic" and said he looked forward to their visits. Another said her carers were like friends while staying professional; when she developed a urinary infection, they called the GP themselves. A third described her care as excellent and said she had built real relationships with her team. A fourth said his carers went the extra mile, checked him for pressure sores, and took time to chat.

Two patients gave more qualified accounts of their care. One patient said some carers were very good but some of the younger ones seemed hesitant and inexperienced, spent time on their phones, and had not got to know him; he sometimes had to tell them what needed doing. Another praised her reablement carers, then found they "just stopped coming" when her usual team resumed, and no one explained the switch.

One care package did not meet the patient's needs. The patient is bedbound and fully dependent; her family described rushed visits, burnt and cold meals, and care that was not built around her. Her full account is in the patient stories for hospital to home.

Costs became a concern during one patient's reablement journey. A patient receiving reablement was assessed by a social worker five or six days in and told that after a week he would have to contribute towards the cost of any continuing care. He cannot afford it. A prepayment card, with £20 towards an hour's care so his wife could take a break, was mentioned but never fully explained; he and his wife were left confused and worried about what was coming.

Physiotherapy and rehabilitation

Patients at home were asked whether they had occupational therapy or physiotherapy in place. Nine of the 11 did or had it upcoming; two had none. While the figures appear reassuring, the reality was more complex. Patients' experiences fell into three clear groups.

Where therapy was active, it worked. One patient has physiotherapy three times a week after a stroke, and exercises were reviewed and adjusted at every visit. Another has home physiotherapy and equipment (a walking frame, a toilet frame, a downstairs bed) and can now make his own cup of tea.

Where it was booked, the queue was long. One patient was told there is a waiting list of around ten weeks for community physiotherapy. Staff kept him informed about where things stood, which he appreciated, but he feels the wait is holding his recovery back and is considering paying privately in the meantime. Another is waiting a longer duration for an outpatient appointment.

Where it was absent, it was simply absent. One has had no physiotherapy or occupational therapy input since his assessment in hospital. The other came off physiotherapy before leaving: the ward team attempted a session, she found it too uncomfortable to continue and returned to bed, and she was discharged from physiotherapy in hospital, with none arranged since. For one patient, therapy was arranged but never got going. An occupational therapy assessment was arranged at short notice, and on the day she felt too anxious to get out of bed, so it could not go ahead. A member of the team remarked that they had driven a 40-mile round trip to see her — a comment she and her family felt was not an appropriate thing to say to an anxious patient. She was left feeling dictated to, and no physiotherapist has visited her at all.

Six of the 11 had a recovery plan; five did not, and the line between the two was blurred. One patient answered no but described physiotherapists setting and adjusting goals every visit. Another answered no, with no goals and no

encouragement discussed, and he felt the difference. One found the question hard to answer at all: a stroke has changed her circumstances, and she is no longer sure about the knee replacement she is high on the waiting list for.

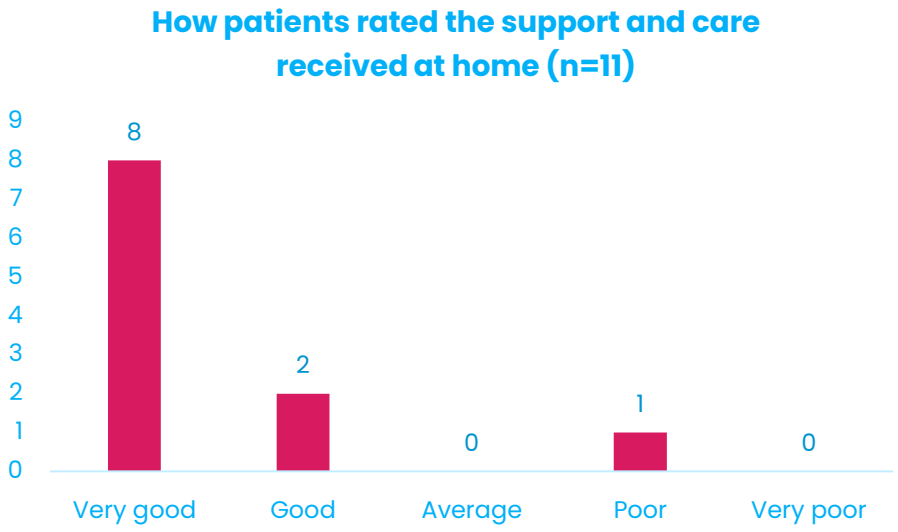
Families holding it together

Family support underpinned almost every discharge home in this group. Daughters managed medication, appointments and hospital liaison. Wives handled prescriptions and meals. Parents housed a daughter recovering from a stroke. Families also caught the errors: the insulin pen without a needle, the injections swapped for tablets, the discharge letter that never arrived. Two patients ended their care packages early because family could cover the need, one after managing a weekend on her own, the other so the carers could go to people who needed them more. Family involvement is a strength of these discharges. It is also what several of them depended on.

Feeling safer at home

Nine of the 11 felt safer or more comfortable at home. One felt no difference, because her hospital stay had been so good. One felt she would have been safer in hospital. For those glad to be home, the reasons were clear: they could enjoy their own bed, the freedom to "potter" about safely instead of waiting for supervision, and relief from a mixed ward where patients going through detox could be heard in pain and distress. As one patient put it: "There's nothing better than your own home."

Eight of the 11 rated the support and care at home as very good, two as good, and one as poor.



What patients told us: hospital to home

One patient was admitted to Leighton from a 24-hour care facility after her oxygen dropped overnight, below what the facility could safely manage. She was discharged to her own home, with four carer visits a day and no one with her at night. Her family asked for her to return to a care facility and were told funding was not available; they told us they felt she had simply been sent home to die. At home, the carers do the basics. Meals arrive burnt or cold, toast is microwaved rather than remade, and there is often no hello or goodbye, so she sometimes does not know they have left. The heating has been turned up where she, bedbound, cannot reach it. The family have noticed occasional light bruising after personal care, which they believe was not intended but too rough. No recovery plan or goals have ever been discussed. Her daughter said it is hard to get the carers to see her mother as a human being rather than £12.21 an hour. The family would have liked an official handover meeting between hospital and care agency, with them in the room. They rated the care at home as poor. (Patient F)

One patient's reablement carers visit three times a day and have been "absolutely fantastic": patient, pleasant, nothing too much trouble. The visits also give his wife, who cares for him, a real break. Then came the financial assessment, the news that he would have to contribute, and a prepayment card scheme nobody quite explained. He is worried, mostly for his wife. He does not want her to struggle because of it. (Patient E)

One patient's discharge was delayed three days while her care package was assembled, then everything moved fast. She called it "absolutely wonderful." Her carers listened, understood, and went the extra mile through a difficult first week. Once she managed a weekend on her own, she asked for the package to end, and it did. She is back to running her own life. (Patient J)

One patient's goal is to dress himself within six weeks. His carers have shown him how to stand and dress safely and check regularly for pressure sores. The one thing holding him back is the ten-week wait for physiotherapy; he understands why, but is thinking about paying privately rather than lose the time. (Patient K)

One patient said her reablement carers were very good: they brought her tablets and drinks and always asked what she needed. Then they stopped coming, without explanation, as her usual carers took over. She prefers her usual team, whom she knows well. She would just have liked to be told. (Patient I)

One patient said some of his carers were great, but some younger ones struggled to hold a conversation, seemed unsure of themselves, and spent time on their phones. Nobody has talked to him about goals. What he misses most is being known: he feels building that relationship is part of the care. (Patient Q)

2. Hospital to care setting

6 patients discharged to a care setting

Six patients went from Leighton to a care setting, and their stays had different purposes and lengths: a six-day rehabilitation stop, a four-night stay while a friend returned from holiday, a self-funded respite of two months, and three longer stays with no fixed end. Three patients were still in their care setting when we visited. Three had moved on; their journeys home are covered in section 3.

What distinguishes this group is how the placements came about. In Phase 1, being discharged to a care home was a source of anxiety for several patients, often because they knew little about where they were going. In Phase 2, most of the six described the move as accepted or chosen rather than imposed. One called it the safe decision. Another chose and funded the placement herself, against the discharge the hospital had first proposed. The step itself made sense to them. What was often missing was a plan for what came next: rehabilitation with goals, a clear point of contact, or a route back home.

Arrival and first days

Five of the six had adequate food on arrival; one person was lactose intolerant, and there was nothing she could eat on her first evening. For three of the six, the first hours were where things went wrong. One arrived at 4pm, was given a cup of tea and an evening meal in the lounge, and then nothing: "no one talked to me." It was 8pm before a staff member showed her to her room, and only because she asked. Another found her name and medication missing from the afternoon medication round; her account of the four and a half hours that followed is in the patient stories for hospital to care setting. A third arrived feeling sick, without the anti-sickness medication that had been stopped at discharge, and did not want to eat for days.

Rehabilitation and clinical input

Four of the six patients were seeing a physiotherapist or occupational therapist, and each intervention was individually tailored to develop and strengthen the patient's mobility. One patient practised the stairs and made cups of tea, rehearsing for home. Another was walking a little further each session, with the physiotherapy team due to assess her house. A third was practising standing with a physiotherapy lead he found encouraging. A fourth had an occupational therapist assess the friend's house she was moving to and order the equipment in time for her arrival.

The remaining two patients received no physiotherapy or occupational therapy support. One said there was no structure, plan or goals, that she had been left to get on with it and expected to be self-sufficient. The other had chosen and funded her own move to the care home, a pathway that would not have carried NHS therapy input with it; five weeks in, she had seen no physiotherapist and would have welcomed one, her last therapy having been in hospital. Healthwatch suggested she ask her GP about a self-referral.

Only two of the six had a recovery plan, and the gap showed in one conversation: a GP told one patient he would walk again, but with no plan he

knew of behind that hope, he did not believe it. Four of the six had seen a GP at the care setting; one had not needed to in a four-night stay, and one had not been seen.

Daily care and staffing

Five of the six felt staff understood their needs and the support was adequate. The sixth gave the fullest account in this report of what stretched staffing looks like from a resident's chair: call bells answered, but not quickly; care that felt generic rather than personal; afternoons when you don't see a soul; staff who "can get a bit niggly with you as they're so busy." The same patient also praised parts of her care. When she asked for a raised toilet seat, it appeared immediately. And the district nurses who come every other day to check her legs and change her dressings are, in her words, "fabulous."

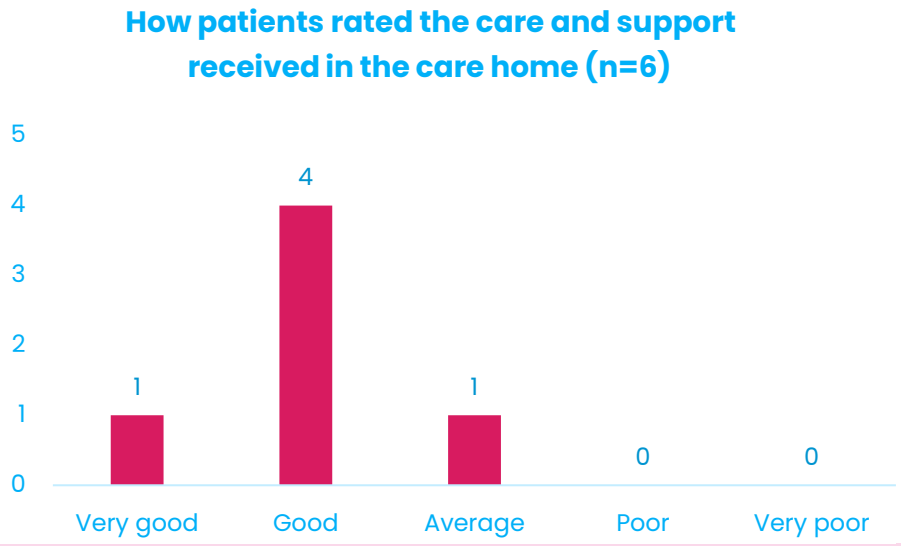
Others described smaller versions of the same pressure. One patient said she is helped when she needs it, though some staff are more helpful than others and mornings can mean a wait; she understands that others in the home need more help than she does. Another noted that most employees were lovely, with some "notable staff" among them. However, initially, they spoke to her in a manner that suggested they assumed she could not understand, possibly presuming she had dementia. Once she spoke, they adjusted.

Company and isolation

Loneliness in the care settings was individual rather than universal. One patient feels lonely at times and has joined only one activity; she stays in her room for fear of missing visitors, who have far to travel, and preferred the hospital ward, where there was company and everything is within reach. Healthwatch raised this with the home, whose staff said they invite her to activities and will keep doing so. Another patient says she never feels isolated: she prefers reading in her room, and staff bring her books and magazines from the lounge when she asks. A third finds the television in his room a kind of company in itself.

Paying for care, and the social work gap

Two of the six were paying for their own placements, and their experiences sat at opposite ends. For one, self-funding meant control: she and her family chose the home, the length of stay, and the care company that would support her afterwards. She called it the best decision. For the other, self-funding was associated with limited support and no clear plan: she had seen her social worker once in hospital, to go through her finances, and once since. In hospital she had been told to expect about a month at the home. Three weeks in, there was talk of going home the following Tuesday, with nothing visibly arranged, the cost mounting, and her friends far away. What happened next is described in the closing account, a discharge that failed. One of the six had a social worker.



What patients told us: hospital to care setting

One patient's room is almost the farthest from the dining room. With her walking frame that leaves her breathless, the journey takes 40 minutes, so she has to set off around 11:50 to reach the dining room for a 12:30 lunch. There are no rest points along the corridor. One day, feeling particularly tired, she asked a staff member for help with the walk and was told, "you can walk, we've seen you walk." (Patient T)

One patient arrived at the care home at 3.30pm. At the 4.30pm medication round, her name and medication were not on the list. Staff said someone would come back; no one did. She pressed the call bell as the pain built; no one came. By 8.30pm she was phoning her family, pleading to be taken out of the home so she could take her own pain relief. A nurse reached her at 9.10pm, knowing nothing of the delay, and took charge: tramadol and paracetamol that night, and, on discovering the hospital had not sent her Oramorph (a morphine-based pain relief) at all, a prescription arranged through the out-of-hours GP for the morning. Despite this, she rated the home's care as good, and said most staff were lovely. (Patient Z)

One patient had been due home in early this year with two carer visits a day. Shortly after our Phase 1 conversation ended, a doctor decided she would not be discharged after all, and she spent two more weeks on the ward. In that fortnight, she was finally prescribed the pain relief she and her daughter had been asking about since her first weeks in hospital, and given a gutter frame (a walking frame that takes weight through the forearms) far better suited to her rheumatoid arthritis. By the time discharge came round again, she and her family had made their own arrangement: privately funded respite at a nursing home. She said she had known she wasn't strong enough for the original plan, and that deciding for themselves, to their own timings, was much better. (Patient U)

One patient has settled. The food is very good and flexible; he has told the kitchen he'd rather have more meat and potatoes, and they oblige. He has

his own space and a television that keeps him company, though the air mattress is not comfortable. Physiotherapy has him practising standing, and the physio lead is encouraging. He believes the aim is to get him mobile and eventually home, but he knows of no plan, and when the GP suggested he would walk again, he did not believe it. (Patient A)

One patient feels lonely at times and has joined an activity. She is scared of missing a visitor; home is a long way away, so she stays in her room to be sure she is there when someone comes. She liked the hospital ward better: more company, and everything within reach. But she is clear the stay has helped her, and that she could not have gone straight home. (Patient L)

3. Care setting to home

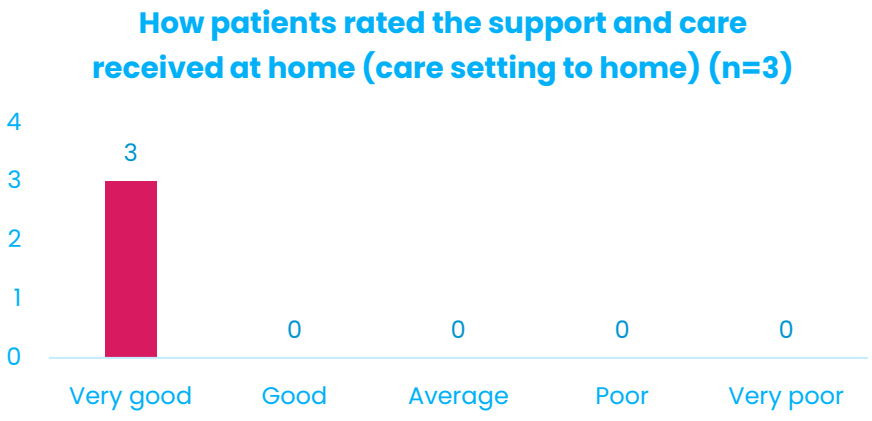
3 patients returned home from a care setting

Three patients completed the full discharge pathway, moving from hospital to a care setting and then back home. This section follows the final stage of that journey.

The journey home

All three transitions home were largely smooth. Two patients were collected by relatives, one using a wheelchair loaned by the care home to reach the car. The third was driven by the friend she was moving in with, and the only difficulty arose at the point of departure. A member of staff escorted her to the car, but she and her friend were left to manage the transfer without assistance. No one had practised steps with her or assessed whether the property would require a ramp. Eager to leave, she chose not to raise the issue with the care home. On arrival home, with her friend's help, she managed the step into the house.

None of the three had delays with medication once home, though one care home was slow in preparing the medication before departure. One unexpected administrative issue emerged once a patient was home: she had understood she remained registered with her own GP while temporarily registered with the care home's practice, but on ringing her surgery was told she would need to re-register. A receptionist completed it by phone due to a glitch in the online system. Our question about whether she had enough medication prompted her to finish the registration promptly, so repeat prescriptions would not be held up. All three rated the support and care they received at home as very good.



What patients told us: care setting to home

One patient spent six days in her care setting rehearsing everyday tasks such as climbing stairs and making cups of tea before returning home to her brother, with support from a daily care visit and district nurses. She said she was very well looked after at every stage and that the rehabilitation got her moving again. She is not yet back to doing her own shopping, although she intends to be as soon as she is able. (Patient C)

One patient came home after two months of self-funded respite to three daily visits from the care company she chose herself: The carers help with whatever is needed — ''anything I need doing really" — from laundry and emptying the dishwasher to ironing, with the patient directing the tasks. The carers took over her medication because rheumatoid arthritis makes blister packs difficult, all except one night-time tablet she administers for herself. When a parcel went missing, a carer checked with the neighbours and found it at the wrong address. Equipment and extra grab rails were due the day after Healthwatch's visit. (Patient U)

One patient has been at her friend's house for three weeks. Her care visits have reduced from two a day to one as she has progressed, at her own pace; physiotherapists visit weekly with clear goals, and on the day Healthwatch visited, the physio arrived with news from her consultant that her knee could be "unlocked." She said the support has helped her recovery "a million percent" and described the staff as "respectful, professional, thoughtful, good fun. They are also respectful to my friend, whose home it is." (Patient Z)

What the findings tell us

Whether a discharge worked came down to how much say the patient and their family had in it. Where they could shape the pathway, by choosing respite, bridging at a friend's house, or ending a care package once family could cover it, support was rated highest and recovery was described with confidence. Where decisions moved around the patient, through a funding refusal, a placement without a plan, or a homecoming to a house that was not ready, the system's gaps showed first, and it was the patient who felt them most.

Those gaps were almost always at a handover: the point where one organisation passed the patient on to the next. The practical side of leaving Leighton mostly worked. The timing felt right, the transport crews were widely praised, 12 of the 14 left with enough medication, and every patient at home had community services involved. It was the joins that failed. Nine of the 14 left with no named person to call. Three discharge letters were missing, contradictory or incomplete. A medication list did not follow one patient to her care home, and another patient was returned to a house that was not ready. The reason for a delay usually had to be asked for. That is why 12 of the 14 could still call their discharge safe and positive: they were endorsing the decision to move them on, not the way it was carried out.

Family and money were what determined who had a say. Family involvement runs through almost every good outcome, and was often how a patient kept any grip on their own discharge at all. Money shaped a handful of journeys: a care contribution that arrived as a surprise a week into reablement, a ten-week physiotherapy wait weighed against the cost of going private, and two self-funded care home beds, one an act of control and one a source of mounting worry.

A further stage of the project will return to these patients for a longer-term follow-up conversation. That data will form part of the final *Discharge from Hospital* report.

What one patient told us: a discharge that failed

This account sits partly outside the survey figures. The patient completed her Phase 2 interview at the care home, but her third-stage survey could not be finished. It is included because of what it shows. The patient was funding her own care and did not have family or close friends nearby to help her navigate the system — the two things that, elsewhere in this report, most often made the difference between a discharge that worked and one that did not.

Twelve weeks after her discharge from Leighton, Healthwatch returned to the care home expecting to find the patient back in her own house. She was not. In March, Adult Social Care had arranged her discharge home. It failed the same day, when she could not be safely supported into bed. Adult Social Care initially suggested a taxi to return her to the care home; staff at the home considered that inappropriate and drove out to collect her themselves that evening. At her house, care home staff found it cold, with the boiler and some light fittings not working, difficult access, an unsuitable bed and no mobility aids. This, they told us, was despite assurances from Adult Social Care that the property had been assessed, cleared, cleaned and repaired. The [care] home had not been contacted before the discharge to discuss her care needs.

In hospital, she had been told to expect about a month in the care home. "Hopefully after that I can go home," she told us then. At twelve weeks, she remained there, paying privately, distressed by the silence from Adult Social Care, the mounting cost, and the distance from her friends. She asked Healthwatch to raise these issues on her behalf, and for a meeting where everyone involved could agree on a plan. The visit ended early when her pain worsened and staff were called to help.

Following the visit, Healthwatch Cheshire's Service Lead raised the case with Winsford Adult Social Care, who provided information about an organisation that supports people arranging care as private funders. Healthwatch passed this to the care home's manager and administration lead. Throughout this report, the patients whose discharges went most smoothly were those with a family member or friend to coordinate on their behalf. This patient had neither, and was self-funding — and it was Healthwatch, not the system, that eventually stepped into that gap.

Service Provider Responses

Mid Cheshire Hospitals NHS Foundation Trust welcomes this report from Healthwatch Cheshire and the valuable 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 many patients spoke positively about the care they received during their hospital stay, consistently highlighting the kindness, compassion and dedication of ward staff. These experiences reflect the commitment of colleagues who support patients and families through what can often be a challenging period.

The findings also identify opportunities to strengthen communication, information sharing and discharge planning. In particular, patients highlighted the importance of receiving timely information, having a clear understanding of what will happen next, and feeling confident about the support available after leaving hospital. The experiences described in the report demonstrate that these issues often span organisational boundaries and require a joined-up approach involving acute, community, primary care, social care and voluntary sector partners.

Improving discharge remains a key priority for the Trust and our wider health and care system. Through our Integrated Discharge Team and system partnerships, work continues to improve communication, strengthen patient and carer involvement, support smoother transitions between services and ensure people are better prepared for the next stage of their care and recovery.

Healthwatch Cheshire's work provides valuable insight into the lived experiences of local residents and will help shape ongoing improvement activity. As this represents the first phase of a wider programme of work, the findings will be considered alongside future stages to build a fuller understanding of how discharge arrangements translate into people's experiences and outcomes after leaving hospital.

We recognise that behind every statistic is an individual patient and family experience. While many people felt informed, supported and ready to leave hospital, the report also highlights examples where communication, coordination or information did not fully meet patients' needs. We are committed to learning from those experiences and using the findings to help shape safer, more person-centred discharge pathways across Mid Cheshire and with partners across the wider health and care system.

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

Adult Social Care in Cheshire West and Cheshire values the learning from this report from Healthwatch Cheshire and the insight it provides into the experiences of Cheshire West and Chester residents upon discharge from hospital into care services. I am assured that the report presents largely positive evidence regarding the effectiveness of community support, reablement and discharge pathways, with most patients reporting safe outcomes and positive experiences. However, there are clearly areas we need to work on as a system to improve discharge coordination, communication, and information sharing, particularly at times of transition. There is also further work to do with regards to improving the experience and information available to or self funding residents. We have recently commissioned a new support service for self-funders, CHS, and it is hoped this will improve the experience.

These findings support our continued focus on integrated discharge arrangements, person-centred planning and the need for continuous service improvement across our partnerships in health and social care. The relationship between Leighton hospital and the Local Authority is strong and we remain committed to ensuring our integrated discharge pathways and our intermediate care services provide a seamless experience that promotes people's independence and wellbeing.

Assistant Director, Adult Social Care Operations
Cheshire West and Chester Council

Thank you again for the reports to date, the findings have been really insightful and very much shaped our new Home First Model that we are currently piloting in Mid Cheshire.

This really looks to positively respond to the points raised around early, consistent communication and advice to patients, relatives and carers. Additionally, we are proactively planning discharge with patients and the Home First team formed from Therapists, Nurses and GNA (Care Support Workers) provide support for the first days/week while transitioning back into the community setting prior to handover into our local neighbourhood team.

Phillipa Morrant, Deputy Director
Central Cheshire Integrated Care Partnership (CCICP)

Next steps

This report covers the post-discharge experience of the Cheshire West and Chester residents from Phase 1, from the day they left Leighton Hospital through to their time at home, in a care setting, or back home from a care setting. A further stage of the project will return to the same patients for a longer-term follow-up conversation, covering their overall view of the discharge process and any issues that have arisen since. That data will be incorporated into the final *Discharge from Hospital* report.

A parallel Phase 2 report for Cheshire East residents, following the same cohort from Phase 1 at Leighton Hospital, has also been produced.

The final *Discharge from Hospital* report will bring together findings from all phases and will include recommendations. All West reports are shared with Mid Cheshire NHS Foundation Trust, Cheshire West and Chester Council, and Cheshire and Merseyside ICB, and published on Healthwatch Cheshire's websites.

Appendices

Appendix 1 – Interview Notes

Appendix 2 – Survey Questions

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