healthwatch Cheshire East

Discharge from Hospital

Phase 2: Post-Discharge

August 2026

Contents

Contents 1

Executive Summary 2

Introduction 4

Methodology 6

Findings 8

- Hospital to home 11
- Hospital to care setting 15
- Care setting to home 19
- What the findings tell us 21
- Service Provider Response 22

Appendices 24

Executive Summary

This report is the second phase of Healthwatch Cheshire East'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 the hospital through to how they were settling into life at home or in a care setting weeks later.

Between December 2025 and March 2026, Healthwatch contacted the 20 Cheshire East residents who had taken part in Phase 1. Thirteen agreed to a follow-up interview. Two had moved to end-of-life care since their hospital discharge, and five could not be reached despite repeated attempts. Of the 13 interviewed, seven had been discharged directly home and six to a care setting. Three of those six subsequently returned home during the course of the project, giving a fuller picture of the journey through all three routes.

What we found

On the day of discharge itself, the practical mechanics — medication, transport, and the appropriateness of timing — were largely handled well. Eleven of the 13 patients felt the timing was right, and all 13 left with sufficient medication; ambulance and Red Cross crews were consistently praised. Waiting to actually leave was a different matter, though: for some patients this stretched from hours into days, and one patient waited over a week.

What happened once patients left the hospital varied widely, and for some, it fell far short of what they needed — depending heavily on the setting they arrived in and what had been put in place for them. **Eight of the 13 patients had no named point of contact after discharge** — no number to call, no coordinator to reach if something went wrong. For some, a care home, care package, or family filled that gap. For others, no one did.

Among those who went directly home, some had excellent care packages and felt well supported. Others struggled from the start. One patient was readmitted to hospital within days, diagnosed with pneumonia and blood clots; his family felt he had been discharged before he was medically fit. Another's family found themselves managing her care after finding the arranged package wholly inadequate — and ultimately arranged a care home placement themselves and paid for a private ambulance to move her, after being told the patient would "have to be dying" before the hospital would consider that option.

Among those who went to care settings, experiences varied widely. Some patients felt genuinely well cared for, while others reported feeling isolated. They told us that their dietary needs were often overlooked, personal care was not provided, and there was little to no rehabilitation offered. For many, the decision to move to a care home felt imposed rather than mutually agreed upon. This theme was evident in Phase 1 and continued into Phase 2.

Across all journeys, two themes were consistent: the gap in physiotherapy and rehabilitation follow-up, and the emotional weight of the transition, which the formal care system largely did not address.

- **13** patients interviewed for Phase 2
- **8/13** had NO designated point of contact after discharge
- **13/13** transferred with sufficient medication
- **4/13** did not feel their discharge was safe or positive

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

Introduction

What is Healthwatch Cheshire

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

Background

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

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

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

While 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.

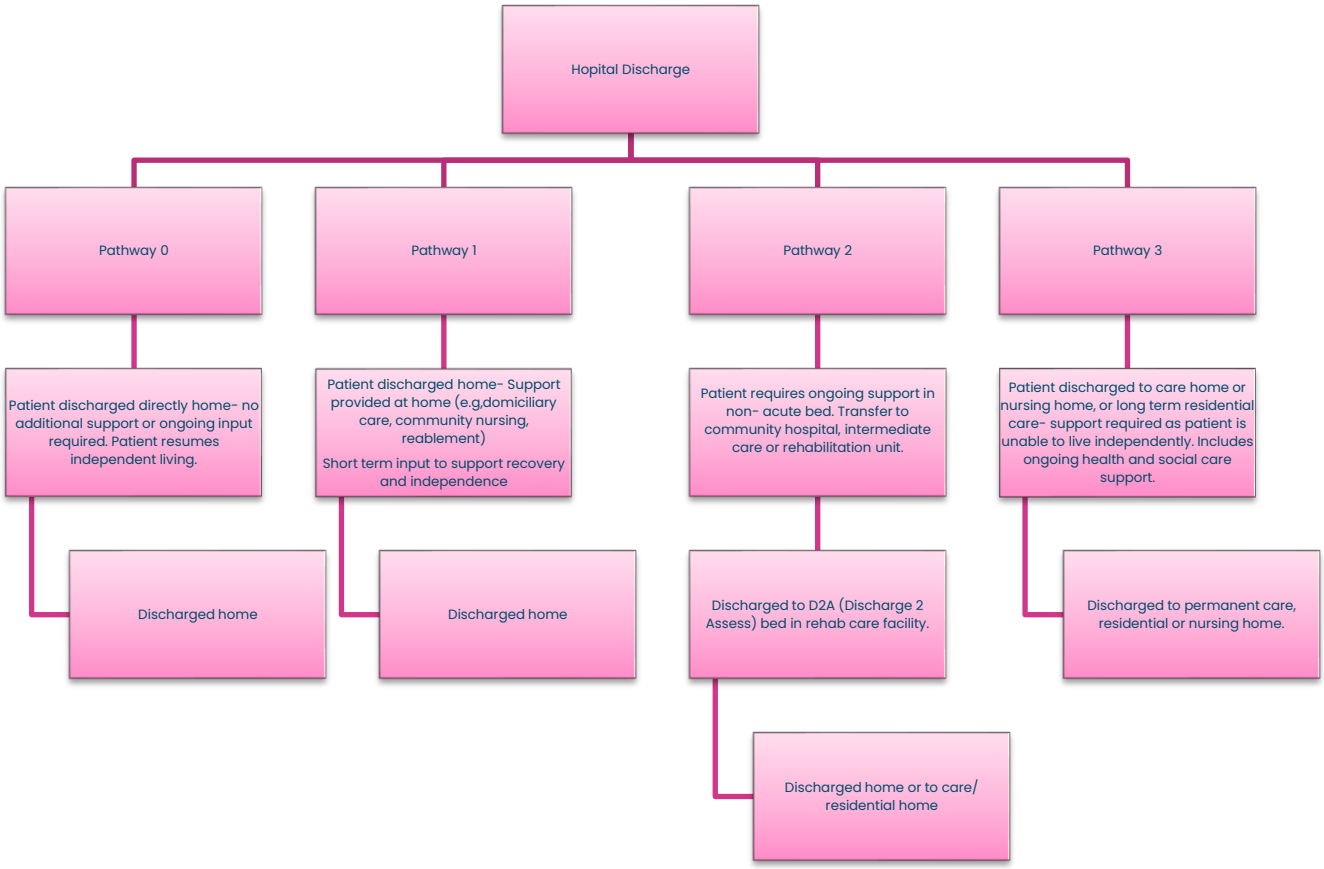
Clear communication, coordinated planning, and involvement of patients and families are central to achieving a streamlined and effective discharge experience.

Purpose of this report

This report focuses on the post-discharge experience of Cheshire East residents who took part in Phase 1. 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 to their own home

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



The findings from this report will be shared with Mid Cheshire NHS Foundation Trust, Cheshire East Local Authority, 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 East residents who participated in Phase 1 and agreed to be contacted again as part of this project. Thirteen gave their time to a follow-up interview, and in several cases family members and carers took part on behalf of patients who were unable to speak to us directly. 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 East 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 interactions with several separate services, which are referred to in this report by their commonly used names. These include reablement (short-term care to help patients regain independence, commissioned by Cheshire East Council); IPOCH (Integrated Placement of Care Hub — a rehabilitation and support team); and commissioned domiciliary care agencies. Where a patient received support from more than one of these services in parallel, this is noted. "Care package" refers to the arranged carer visits.

How patients were contacted

Healthwatch attempted to contact all 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 or at the care setting they had moved to.

In some cases, patients were no longer able to speak to Healthwatch directly because of changes in their health. Where this applied, and where consent had been given during Phase 1, a family member or carer took part on their behalf.

Of the 20 patients contacted:

- Two had moved to end-of-life care following their discharge from Leighton Hospital and did not continue to the next stage
- Five could not be reached despite repeated contact attempts
- Thirteen, who agreed to a follow-up interview, form the basis of this report

When the interviews took place

Phase 2 interviews took place between 8 December 2025 and 25 March 2026, at varying points after each patient's original discharge date.

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 13 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 returned home and also answered Q55–Q75

Where in-person interviews took place

In-person interviews took place at patients' homes and at the care settings they had moved to. The care settings visited for Phase 2 included Station House Care Home in Crewe, St Stephen's Care Home in Sandbach, Overdene in Winsford, and Richmond Village, Nantwich. Where an in-person visit was not possible or preferred, interviews were conducted by telephone.

Who took part and what the findings are based on

Findings draw on 13 interviews, combining closed-question responses with notes taken during each conversation, consistent with the approach used in Phase 1. All comments are anonymised.

Section	Questions	Who	n
Day of discharge	Q25–Q40	All Phase 2 participants	13
Care setting experience	Q42–Q54	Patients in a care setting	6
Home experience	Q60–Q75	Patients at home (7 discharged directly, 3 via a care setting)	10

Findings

Of the 20 Cheshire East patients from Phase 1, 13 agreed to a Phase 2 interview. Seven were discharged directly home. Six were discharged to a care setting. Three of those six subsequently returned home during the course of the project.

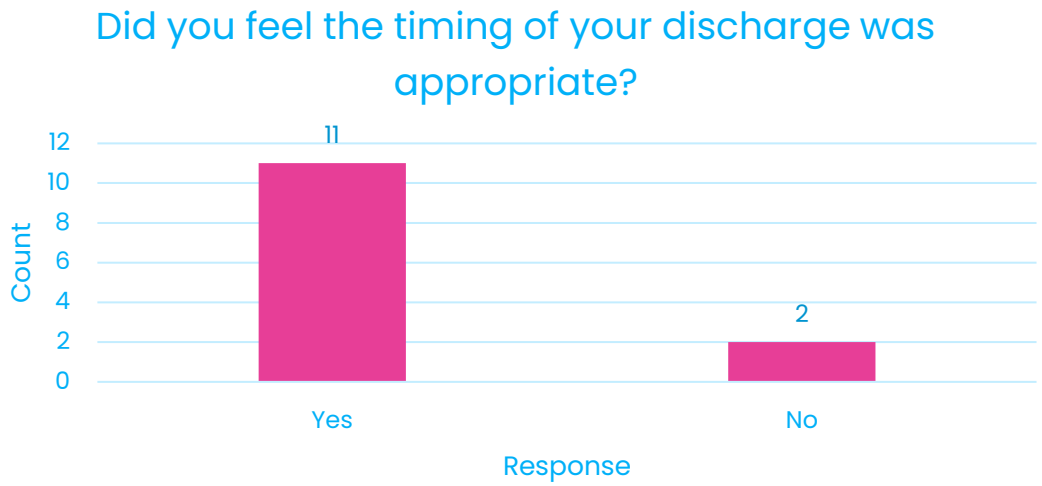
The findings are organised around where patients went after leaving hospital. We begin with the day of discharge — the experience every patient shared — before following three distinct routes: directly home, to a care setting, and from a care setting back to their own home. The structure is intentional: what happened to patients depended significantly on where they were going and what was in place when they got there.

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 13 patients, regardless of where they went.

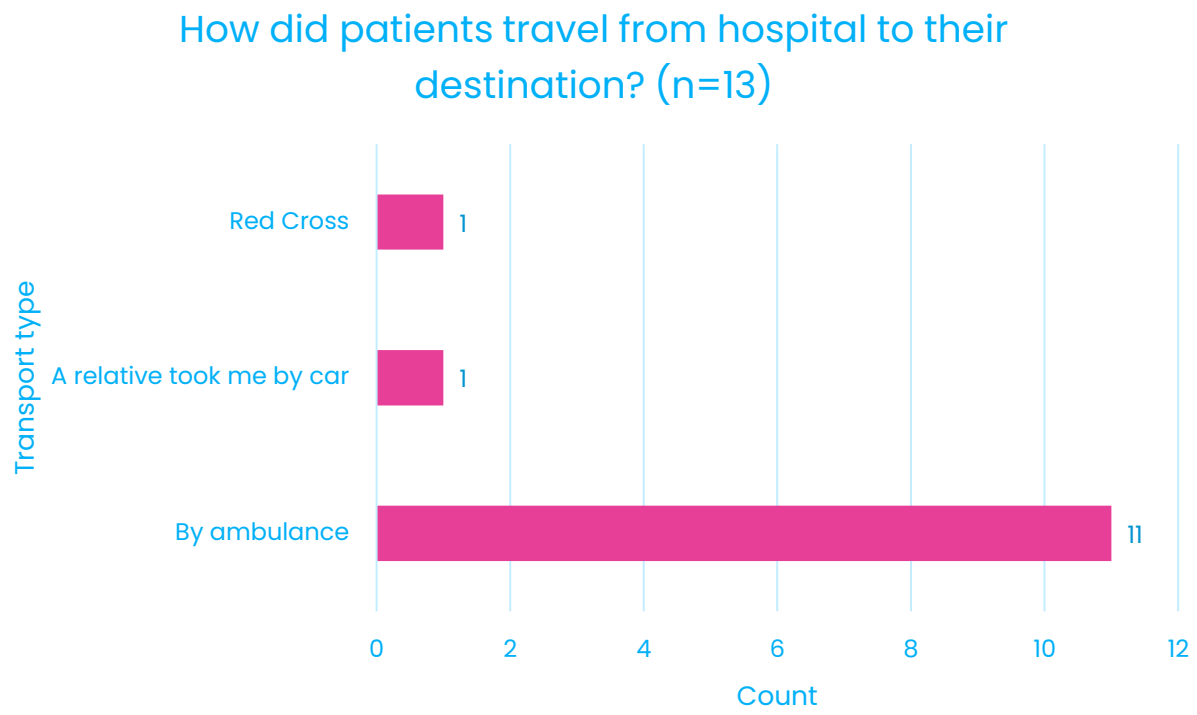
Timing and waiting

11 of the 13 patients felt the timing of their discharge was appropriate, albeit waiting to be discharged wasn't. Of the two remaining patients, one felt it was an excessively long wait, and the other felt that their discharge destination was inappropriate from the beginning.



Waiting remained a significant theme. In Phase 1, patients described long spells in the discharge lounge before leaving. Phase 2 showed the same pattern. Some waited even after being told they were ready — for transport, medication, or a care home place. One patient's first discharge attempt ended with five nights in the discharge lounge. They were then moved between two wards over the next few nights before returning to the lounge and going home — over a week in all.

Waiting times from being told about discharge to actually leaving ranged from around 12 hours to five days (and in one case stretched to well over a week). Seven patients were told about delays or given a reason for the wait; six were not.



Transport

11 of the 13 patients travelled by ambulance. One was taken by a relative by car, and one by Red Cross transport. The ambulance crews, and Red Cross teams are a consistent bright spot in the Phase 2 findings. Across almost every patient who travelled by ambulance, the crew was described as attentive, practical, and kind. Many patients shared additional gestures of care, such as alerting a neighbour that a patient had returned home safely, assisting a patient with an unusual access issue to their property, providing a wheelchair to a patient who needed one without prior notice, or simply allowing a concerned spouse to accompany the patient during the ride.

Medication

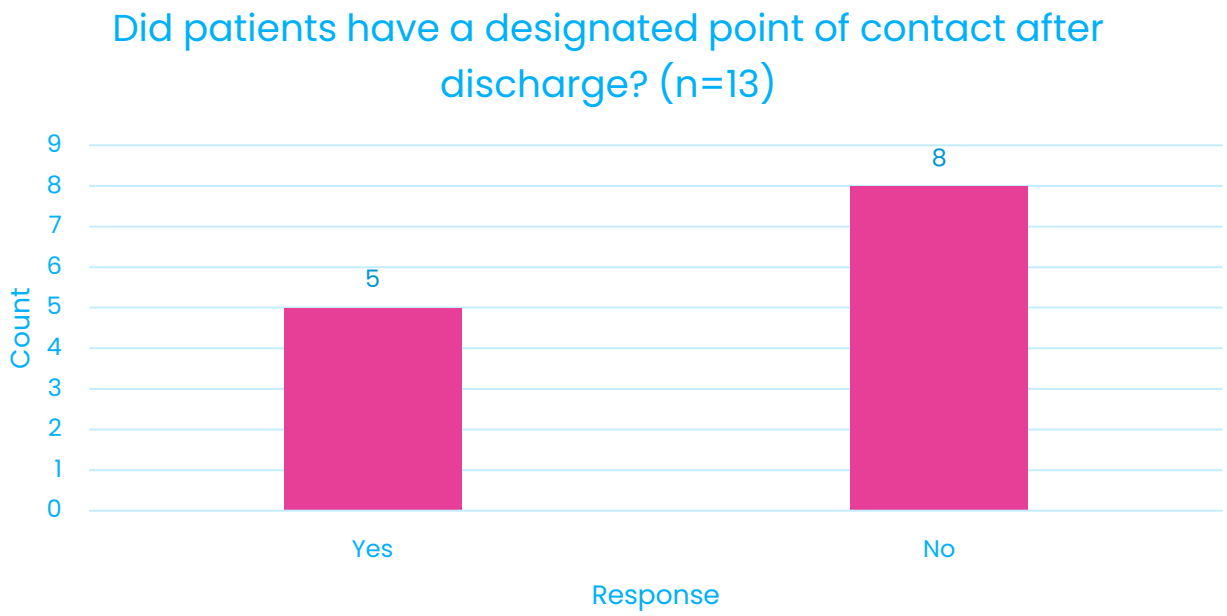
All 13 patients were transferred with sufficient medication. In most cases it was ready and correct, and there were no delays reported at the hospital end. One patient said of the hospital pharmacy: "I can't fault them at all." There were some subsequent issues in the community — a prescription not ready in time, queries between care home staff and a GP — but these are covered in the relevant sections.

- **13/13** were transferred with sufficient medication
- **11/13** had a meal before leaving the hospital

Point of contact after discharge

8 of the 13 patients did not have a designated point of contact after leaving hospital. Five had a named contact — in some cases a discharge coordinator they had an established relationship with, in others the care home or community care team. For those who were not given a contact, the assumption was often that the care home, the carers, or a family member would fill that space. That assumption was not always valid.

This is the single clearest structural gap in the day-of-discharge picture. In Phase 1, patients described uncertainty about what would happen next. Phase 2 shows that uncertainty was not addressed at the point of leaving hospital. For patients where it mattered most — where something did go wrong, or where the first days at home or in a care setting were difficult — the absence of a named contact was both a practical and an emotional gap.



Overall sense of safety

9 of the 13 patients felt their discharge had been safe and positive. Four did not, and for them, the concerns that had surfaced in Phase 1 — about feeling ready, the suitability of the discharge destination, and what would happen at home — had materialised. Those experiences are described more fully in the sections below.

What patients told us: the day of discharge

One patient described the ambulance crew arriving and, finding the hospital bed too wide for the front door, carrying them through the back of the property via the patio. "The crew were very good."

One patient wasn't given a designated point of contact when they left hospital — they assumed everything had simply been passed over to the care home to deal with.

A patient's son found out his mother had been discharged only when he rang the hospital to check on her progress. He had been involved in planning discussions throughout, but was not called when she actually left. He made a formal complaint about the lack of communication.

One patient described being moved between wards late at night on multiple occasions during an extended wait for discharge — sometimes with no explanation. "We're moving," they were told. No further information was given.

A patient said the Red Cross transport team were "really good" — they had a wheelchair ready, let the patient's husband travel with them, and dropped them outside their home so he could help them inside.

One patient had her transport initially refused after ambulance staff felt she'd spoken to them rudely. She explained she'd been woken suddenly after a poor night's sleep in the discharge lounge and felt disoriented; when a staff member prompted her to say thank you, she said, 'What should I be thankful for? You've just woken me up.' Transport was withdrawn, then later returned, and she completed her journey.

One patient described waiting in the discharge lounge for a week the first time they were told they were being discharged, then being moved back to wards, before returning to the lounge and leaving the following day. From first being told they were going home, to actually going home, took over a week.

1. Hospital to home

7 patients discharged directly home

Seven of the 13 patients were discharged directly home from Leighton Hospital. For some, the support in place worked well from the start. For others, what had seemed adequate in planning quickly proved otherwise — and in two cases, the gap between what was arranged and what was needed was significant.

Most had a care package in place, involving carers visiting several times a day. Alongside this, a district nurse, GP follow-up, and physiotherapy or occupational therapy were also arranged. Others relied more heavily on family.

First days at home

For most patients, the practical basics were in place on the day they arrived home — food, medication, and someone around. Several people told us that family members took on significant caring roles in the first days. Some had care visits arranged for the same day they arrived home; others waited until the following morning for the first visit.

For one family, the first days were immediately and seriously difficult. One family described the physical reality of their relative's home as wholly unsuitable from the outset — no bed rail or grab rail in place on the first night, and care visits not starting until the following day. The family took turns watching the patient through the night to keep them safe, which had never been discussed as part of

the care plan. For another, the husband was up through the night and was sleeping downstairs.

Community support and care packages

The 'home' questions — covering community support, physiotherapy, and recovery — were answered by all 10 patients who were at home at the time of interview. This includes the seven patients from this route and the three who returned home from a care setting and are covered in the last section. Figures in this section reflect that ***group of 10****.*

Most patients had some form of community support — most commonly regular care visits, district nursing, and in some cases a GP call shortly after discharge. **8 of the 10** patients at home said community services were supporting them; the remaining two said they were not. Six felt the handover from hospital to those services had been good; four did not.

The quality and consistency of care packages varied significantly. Some patients were happy with their carers who were 'attentive and reliable'. However, others had different experiences, noting that some visits were very brief, tasks were often left unfinished, and there was a clear discrepancy in what different carers would and wouldn't do.

Funding was a source of uncertainty for some. One patient had completed her financial assessment forms and was waiting to hear from the council; she was unclear how long her care package was funded for and worried about unexpected charges. Another had similar concerns about how long her care would last and what she might have to pay — a reablement worker reassured her that an assessment would be carried out and that her care would "not just stop." In a care setting, one patient's funding had been secured for at least three months, which gave more certainty than others had.

Two care packages raised concerns. In one case, carers barely interacted with the patient, recorded inaccurate entries in the care notes — including a pad change for a patient who wore none — and did not give medication as agreed, leaving the family to do it. In another, the family took over almost all practical care themselves after finding the package so minimal. Five of the nine (one person didn't respond) patients at home said the support they received was sufficient to help them manage daily activities and their recovery. Four did not.

Physiotherapy and rehabilitation

The absence of physiotherapy follow-up was the most commonly raised concern among patients at home. Of the 10 patients at home, five had OT or physiotherapy appointments in place. Four did not. One was unsure. Where physiotherapy was in place, it was not always accompanied by a clear plan or defined goals — patients said they received visits without knowing what recovery looked like or what they were working towards.

Several patients who had received physiotherapy input in hospital expected that to continue at home. For most, it did not. The contrast matters. Most patients at home — 8 of the 10 — had seen a physiotherapist or occupational therapist in hospital. When that input stopped after discharge, without a plan or a handover, patients were left mid-recovery with no clear path forward.

Six of the nine (one person didn't respond) patients at home had no formal rehabilitation or recovery plan in place. Three did.

Being at home: reality versus expectation

In Phase 1, 16 out of 19 patients felt ready to leave the hospital. However, Phase 2 indicates that this feeling of readiness does not always mean they felt adequately prepared to manage once they returned home. Some patients mentioned a notable difference between their expectations and their actual experiences. They encountered practical challenges, such as managing stairs, accessing the bathroom, and dealing with equipment that arrived without clear instructions, which led to difficulties they hadn't anticipated.

One patient said that they had not been given a realistic picture of what recovery would be like. Another said that they knew carers would be coming but did not understand what that would actually mean from day to day, or just how much work would fall to them between visits.

Emotional wellbeing

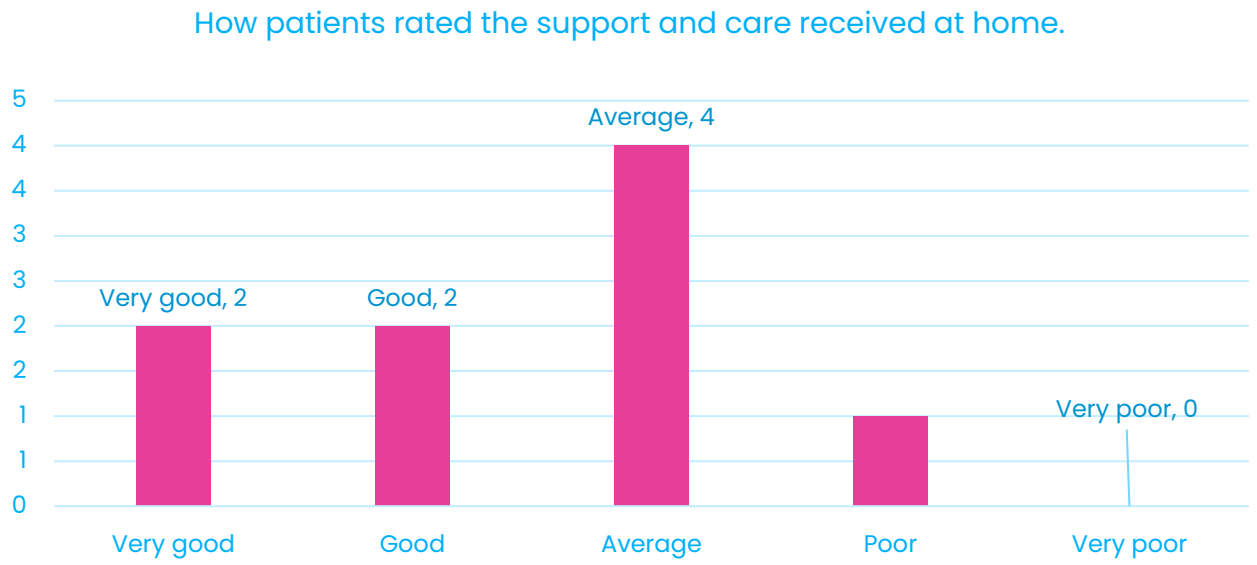
The emotional aspect of returning home was clearly reflected in patient feedback and largely overlooked in formal support. Several patients described loneliness, feeling overwhelmed, or the grief of a sudden and significant life change. One patient said they had not been prepared for how hard it would be emotionally. Another described their home now feeling like a ‘medical environment’ with a hospital bed, equipment throughout, and no longer being able to share a bedroom with their partner.

A third chose to go home originally, but later decided they would prefer a care setting because of the isolation they felt.

No patients mentioned being offered any form of emotional or psychological support as part of their discharge plan. And this sentiment runs across the patients, not just one.

Feeling safer at home

Despite the difficulties some experienced, most patients felt safer and more comfortable at home than they had in hospital. Seven of the ten who answered this question said they did. Two said there was no difference. One said they did not feel safer at home. The value of familiar surroundings, personal independence, and proximity to family came through consistently — even for patients who were struggling with parts of their care.



What patients told us: hospital to home

One patient had an excellent care package from the start — four carer visits a day, a GP visit shortly after discharge, district nurses involved, physiotherapy and occupational therapy arranged. They said their carers were excellent. "They go above and beyond."

A patient's wife told Healthwatch she had felt strongly that her husband was not medically fit to be discharged. Within days of arriving home he was readmitted with pneumonia and blood clots. He has been significantly weaker since, and now needs a great deal more support than was originally arranged. His wife told us she had been "very concerned" — he "was very poorly."

One patient said they were not prepared for how hard it would be. They knew the carers were coming, but not how much would fall to them between visits.

A patient described two separate organisations providing care — one in the mornings, one in the afternoons, each with different remits and different tasks. No one had explained this at the point of discharge. When they asked a morning carer to apply cream, the carer said they weren't permitted to do that. The patient had not been told there were two providers, or that their responsibilities did not overlap. No one had bridged that gap.

One patient said a carer arrived on the final day of the care package and said — within earshot — "thank god for that." The patient and family found this upsetting.

One patient arrived home to find no bed rail or grab rail had been fitted — her daughters took it in turns to stay with her around the clock, which had never been part of the care package. On one occasion a carer wrote in the notes 'changed pad'; the patient didn't wear one. After four days, the family decided she needed to be in a care setting instead. They were told that "the patient would have to be dying" before that could happen. With no social worker in place, the family found a care home locally themselves and paid for a private ambulance to transport her.

One patient, bed-bound and living alone, found being at home lonelier than expected. His son confirmed a care setting had been discussed at the point of discharge, but the patient had chosen to go home at the time. He has since asked to be considered for a care home place after all. "I'm stuck in this bed with no one to talk to, nothing to do," he said. He was waiting to hear which home could take him, close to where he lives.

2. Hospital to care setting

6 patients discharged to a care home

Six patients were discharged to care settings after leaving Leighton. This is the most varied section of the report — from patients who found exactly the right setting for their needs, to patients who said the care was poor, isolating, and in their view 'unnecessary.' What determined the difference was not only the quality of individual care homes, but how the decision to go there had been made in the first place.

The care settings involved were Station House in Crewe, St Stephen's in Sandbach, Overdene in Winsford, and Richmond Village in Nantwich. Three patients were still in their care setting at the time of interview. The other three subsequently returned home; their experiences in the care setting are reflected here, and their journey home is covered in the third section.

Arrival and first days

All six patients had adequate food on arrival. Five felt the handover from hospital to the care setting had been good; the sixth felt little about the move had gone well having had a noticeably better stay at the same care home before. No patients experienced delays in receiving general support once they arrived.

For most patients, the first impressions were neutral to positive. But for some, concerns emerged early on: two patients described not being given any choice in what they ate for the first several days, and in one case dietary requirements for plain, bland food were not catered for at all. That patient lost significant weight during their stay.

Rehabilitation and clinical input

The clearest gap across the care settings was rehabilitation. Four of the six patients had no recovery plan in place. Four had seen a physiotherapist or

occupational therapist, but in most cases this contact was irregular and lacked clear goals.

Three had not been seen by a GP whilst in the care setting.

One patient had been seen by a physiotherapist once during their stay, but no exercises had been given and no follow-up had taken place. Their family raised concerns with the IPOCH team. After that contact, input increased somewhat, though the family remained dissatisfied. As they put it: "It just feels like they've written them off."

Another patient tried walking in the corridor independently — something they felt safe to do — and was told by a staff member not to, without explanation. From that point, they stayed in their room all day, every day. They lost weight, felt completely isolated, and said the care home had made their recovery worse — not because they had not physically recovered from their operation, but because the mental and emotional impact of the stay had been so negative.

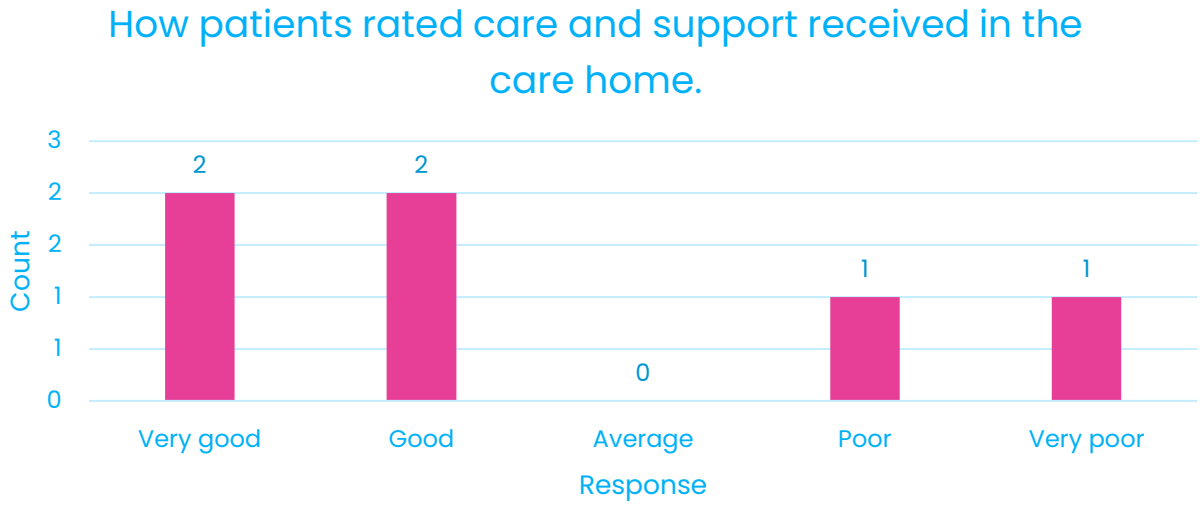
One patient, by contrast, had a physiotherapist visiting nearly every day, with exercises set and progress monitored. An occupational therapist had visited their home to prepare for their return. This patient described the care as generally good. The reasons for this variation were not identified from patient accounts.

Quality of care and staffing

Four of the six patients felt care home staff understood their needs. Two did not. The most significant concerns came from patients and families who described care that was inattentive, inconsistent, or left unfinished.

One patient repeatedly asked for personal care (washing, dressing and personal hygiene tasks) after the first morning and received none. A family member on a separate visit found their relative mid-wash, partially undressed, with no carer present — apparently left before the task was complete. One patient described an issue with eye medication being given once a day instead of twice, which affected their vision during their stay.

A recurring theme across more than one care setting was the difference in care quality between weekdays and weekends. One patient said: "I hated weekends



at the care home. The staff are different — I don't get the same care at weekends as in the week." Another family noted the same pattern. One patient reflected that they were able to advocate for themselves and believed this had made a difference to the care they received. They were aware that not everyone would be in a position to do the same.

In the ratings, two of the six patients described their care as very good and four rated it good or better; two rated it poor or very poor. One patient, who had lived alone managing complex conditions, said the care home gave them safety and company they had not had for some time.

Isolation

Isolation was a consistent theme among care setting patients, particularly those with limited mobility. Several described being confined (reasonably or otherwise) to their room because they could not get around independently, and not being offered help to access communal areas or activities. One patient said staff had not suggested group activities.

Another described the care home as entirely different from being on a ward at Leighton, where there had at least been other patients nearby to talk to.

Two of the six patients in care settings described feeling significantly more isolated than they had on the hospital ward. Both patients were in the same care setting, which suggests the isolation may reflect that care home rather than care settings in general.

Patient agency: having a say in the decision

This theme connects directly to findings from Phase 1 — was the extent to which patients felt the decision to go to a care setting had been made with them or for them.

Phase 1 found one patient who mentioned feeling they had no say in going to a care home. Phase 2 found this was not an isolated experience. Several patients described the decision as having been made by health professionals, with limited opportunity for them to question it or explore alternatives. One patient reflected that because they are very elderly, it was presumed they couldn't think for themselves and make decisions about their own care. As they put it: "It would have been so much better to have come straight home and had any necessary support there."

For one patient, going to a care setting was clearly and genuinely the right outcome — they said so explicitly and with relief. For others, especially those who subsequently returned home and recovered better there, the question of whether the care home stay was necessary remained with them.

What patients told us: hospital to care setting

One patient described feeling genuinely relieved to be in the care home. Living alone before their admission, managing complex health conditions independently, they said the care home had given them safety, company, and a quality of life they had not had for some time. They described the staff as "ace" and said they were much happier there than they would have been at home.

One patient tried walking to the corridor for exercise — they felt safe to do so — and was told by a staff member not to. They stayed in their room from that point, all day, every day. "I was in the room all day, every day. If the door could have been opened, I'd have just walked out."

A patient described care as generally good during the week but significantly poorer at weekends, with different staff and noticeably different standards. "I hated weekends at the care home." They were aware that being able to speak up and ask for things had made a difference to the care they received. And that not everyone would be in the same position.

One patient said they did not feel the decision to go to a care home had been made with them. 'It's as if because you're elderly it's presumed you can't think for yourself and that others have to do it for you,' which, they said, was not the case.

One patient described being told staff would return in 15 minutes and then not doing so, and said some staff were rude and wouldn't let her explain herself. Her eye ointment was given once a day instead of the required twice, which affected her vision. She rated the stay as poor overall, saying only 5 of her 15 days there were good — though the night staff, she said, were consistently better than those on days.

A patient said they would not have chosen to go to the care home and described their two-week stay as having set their recovery back mentally, despite physical recovery from their operation. They felt the placement was unnecessary and that going directly home would have been better.

One patient rated the care at their setting as very good, describing staff as kind, approachable, and attentive, and saying they always had someone to ask if they needed to. They were less clear on any formal rehabilitation plan, saying they'd mostly 'gone with the flow.'

3. Care setting to home

3 patients returned home from a care setting

Three patients had an additional stage before arriving home – hospital, care setting, and then home. For all three, arriving home brought real relief after a period in a care setting that had been difficult. What they found when they got there, and what support was waiting for them, was a mixed experience.

Their experiences in the care setting are captured in section 2. This section focuses on the journey back home and what followed.

The journey home

All three journeys were described as smooth. One patient was transported by ambulance, with the crew described as very helpful. Another was driven home by two members of care home staff. The third was collected by her own carer, who had arranged a taxi. Two of the three had no problems with their medication after arriving home; the third experienced a delay and needed her GP to issue a new prescription.

Arriving home

One described feeling "a hundred times over" safer and more comfortable at home. Another said the improvement in her day-to-day experience was immediate — carers who knew her, proper and regular meals, and a sense of personal control that had been absent in the care setting.

However, arriving home was not without challenges. One patient arrived to find a raised toilet seat had been installed but a grab rail for the shower was on a long waiting list — a non-slip mat was provided in the meantime. A falls alarm had been provided but the patient was unsure how to use it. Their walking aid had come from a relative who had similar surgery. No physiotherapy had followed them home.

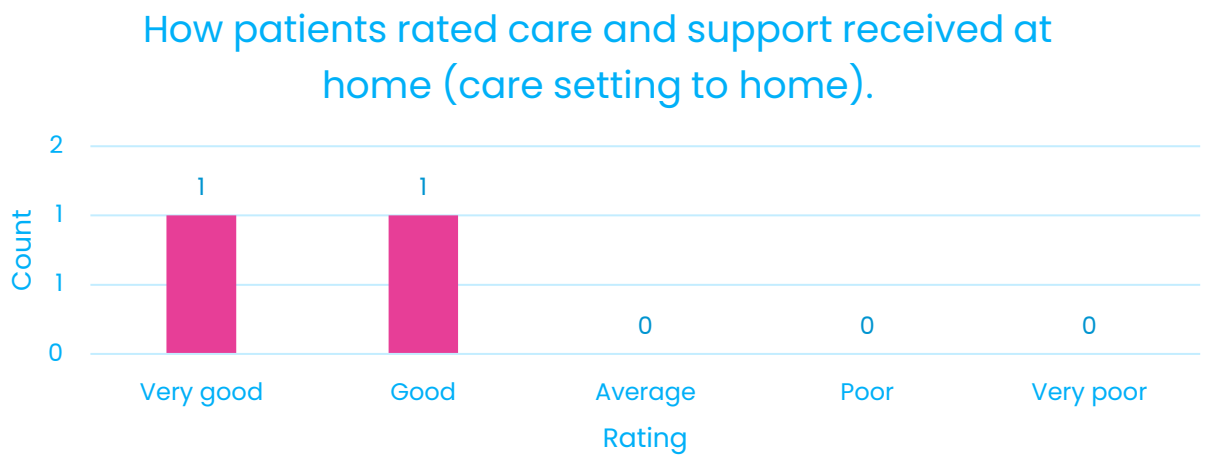
One patient arrived home to a care package that started the same evening. All four care visits were at appropriate times, the handover from the care setting to community services went well, and a physiotherapist followed up with some seated exercises. This patient described the full journey — hospital, care home, home — as having been largely well managed, with the exception that the care home stay lasted five weeks rather than the expected two.

Recovery at home

For patients who had experienced poor care in the care setting, being at home felt markedly better — not just more comfortable, but clinically better in some cases. One patient said her eyesight had improved since getting home because her eye medication was now being administered correctly and consistently. Another described feeling much more in control of her own life, and felt that the care home had not helped her recovery at all — but that being home had.

Physiotherapy remained a gap for two of the three patients at home following a stay at the care setting. One had been told someone would follow up and had heard nothing. The other had had no physiotherapy at all since returning home,

and no recovery plan or goals — she said she pushed herself to keep moving instead. The third patient, who had received regular physiotherapy throughout her stay, continued with a home exercise plan set by the care home physio, with no further input expected.



What patients told us: care setting to home

One patient said being home was "a hundred times over" better than the care setting. They felt safer, more comfortable, and more like themselves. The isolation and inattention of the care home had been very difficult. Being back at home had given them back a sense of control and wellbeing.

A patient described her carers — who now handled medication, shopping, and meals — as consistent and caring, adding that she had built a good relationship with them and they always knew where to find things in her home. She said her time in the care setting before this had felt like "a waste of time" by comparison.

One patient's care package had started the same evening she arrived home. She described her carers as compassionate and caring, singling out one in particular who had gone out of his way to help.

One patient's medication wasn't fully sorted on returning home — her carer had to contact the GP for a new prescription before it was resolved.

One patient said she had never had a recovery plan explained to her, nor been set any exercises or goals. She said she pushes herself to keep moving and getting stronger, determined to stay as independent as she can — managing in the meantime with a walking aid from a relative and a non-slip mat in the shower while she waited for a grab rail.

What the findings tell us

Taken together, the three journeys show a system that handles the logistics of discharge reasonably well, but leaves a gap in what follows. Medication arrives, transport works, and most patients felt the timing of their discharge was appropriate. What was missing — consistently across all three routes — was a named point of contact, a structured rehabilitation plan with an agreed or understood stated goal, and any acknowledgement of the emotional reality of the transition.

The quality of what patients experienced after leaving hospital depended heavily on which setting they went to, how proactive their family was, and in some cases whether they were able to advocate for themselves. Those who could speak up got better outcomes. Those who could not were more likely to fall through the gaps.

A further stage of the project will return to the same 13 patients for a longer-term follow-up conversation. That data will form part of the final Discharge from Hospital report.

What one family told us: a gap, and a fix

This case sits outside the survey figures. The patient did not complete a Phase 2 interview, but her family shared the following account. One patient had been discharged home under Pathway 1 with support from the IPOCH team. It was later agreed she would move off IPOCH so her daughter — who lived out of area — could provide short-term care. The family did not fully understand that taking this on would end IPOCH support, or how demanding the caring role would become. Once she was back in her own home, the family quickly found they could not cope and described themselves as being in crisis, unsure where to turn.

In response, Healthwatch contacted the IPOCH team, as the patient had originally been discharged under Pathway 1 and should have received appropriate support. The IPOCH team confirmed that support had already been in place and advised that two to three follow-up home calls had reportedly been completed following discharge, where daughters were happy for the patient to be discharged into their care.

Healthwatch explained the family's current circumstances to the IPOCH team, the IPOCH team agreed to contact the patient's daughter to review the situation and consider whether a re-referral was required.

As a result this intervention, the IPOCH team reconnected with the family and reinstated short-term care while a further assessment of the patient's needs was undertaken.

Service Provider Response

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

It is encouraging that patients recognised positive aspects of the discharge process, including medication provision, transport arrangements and the care and support provided by colleagues involved in helping people leave hospital. These experiences reflect the commitment and compassion shown by teams across the discharge pathway every day.

The findings also highlight opportunities to strengthen communication, coordination, and continuity of support once people leave hospital. The themes identified around rehabilitation, post-discharge support, clear points of contact and patient experience 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 for partners across our health and care system. Through our Integrated Discharge Team and wider system partnerships, work is already underway to strengthen communication, improve transitions between services and enhance the support available to patients and carers throughout their recovery journey.

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

We recognise that behind every statistic is an individual patient and family experience. While many patients described positive outcomes, the report also highlights examples where people felt unsupported, isolated, or uncertain. 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 the wider Cheshire East health and care system.

Megan Nurse, Chair
Mid Cheshire Hospitals NHS Foundation Trust

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)

At the time of publishing, Healthwatch received no response from Cheshire East Adult Social Care.

Next steps

This report covers the post-discharge experience of the Cheshire East residents from Phase 1, from the day they left Leighton Hospital through to their time at home or 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 rather than published separately.

Alongside this, a parallel Phase 2 report for Cheshire West and Chester residents — following the same cohort from Phase 1 at Leighton Hospital — is in preparation. Healthwatch is also carrying out the equivalent work at the Countess of Chester Hospital, with separate reports covering residents of both areas.

The final Discharge from Hospital report will bring together findings from all phases, both hospital sites, and both resident populations, and will include recommendations. All East reports are shared with Mid Cheshire NHS Foundation Trust, Cheshire East Local Authority, and Cheshire and Merseyside ICB, and published on Healthwatch Cheshire's websites.

Appendices

Appendix 1 – Interview Notes

Appendix 2 – Survey Questions

healthwatch
Cheshire East

Healthwatch Cheshire
Sension House, Denton Drive
Northwich
CW9 7LU

www.healthwatchcheshire.org.uk
t: 0300 323 0006
e: info@healthwatchcheshire.org.uk
@HealthwatchCE
Facebook.com/HealthwatchCheshireEast