healthwatch Middlesbrough

healthwatch Redcar and Cleveland

Hospital Discharge Report

January 2026

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Introduction and Background

Hospital discharge was identified as a key quality priority for the Trust in 2025/2026. In response, we were invited to lead a collaborative engagement initiative focused on improving discharge processes and patient outcomes.

This work aimed to capture the lived experiences of patients, their families, and care providers involved in these discharge pathways - to better understand what helps people transition safely and confidently from hospital to home or residential care and where improvements are needed. By gathering insights from those directly affected, we sought to inform the development of more effective, person-centred discharge processes that reflect real-world needs and challenges.

This work centred specifically on individuals discharged into care homes or supported through domiciliary care packages in the Middlesbrough and Redcar and Cleveland areas.

Key Themes from Care Home Hospital Discharge Feedback

1. **Poor Communication and Incomplete Information**

   Care providers often don't receive enough or the right information when someone is discharged from hospital.

   - **Example:** One team shared that discharge letters are often hard to read or missing key details. They now carry out their own in-person assessments because what's described over the phone often doesn't match the person's actual condition.
   - **Example:** Another provider received a discharge letter that included someone else's personal details, and no mention of visible bruising on the resident.

2. **Mismatch Between Discharge Decisions and Real-World Care**

   People are sometimes discharged with needs that the receiving care setting isn't equipped to meet.

- **Example:** A care team had to sift through pages of discharge paperwork to discover that a returning resident now had nursing needs they couldn't support.
- **Example:** Staff described how patients needing nursing care are being discharged to residential homes, placing them in an impossible position and risking the person's safety.

3. **Medication and Equipment Failures**

   Medication is a recurring issue - either missing, delayed, or not updated.

   - **Example:** One carer praised the Hospital at Home service but said medication delays remain a major problem.
   - **Example:** Another team reported that changes to feeding plans weren't communicated to dietitians, and residents were sent home without enough feed to last.

4. **Hospital Passports and Local Knowledge Ignored**

   Care homes often prepare detailed hospital passports to support continuity of care, but these are frequently overlooked.

   - **Example:** Several providers said their hospital passports, which include vital information about mental health needs and behavioural support, are often disregarded - leading to rushed or unsafe discharges.

5. **Safeguarding and Risk**

   Several examples show how poor discharge planning can lead to safeguarding concerns.

   - **Example:** One case involved a man with alcohol-related memory issues who was repeatedly discharged home despite family concerns. Only after a social worker intervened was he placed in a safer setting.

6. **Emotional and Operational Strain on Staff**

   Staff are under pressure to manage complex needs without the right support, which affects morale and care quality.

- **Example:** One team described how the emotional toll on staff is growing, especially when they're expected to deliver care beyond their remit without additional resources.

Key themes from Domiciliary Care feedback

1. **Inconsistent Communication**

   Communication from hospital staff varies widely, making it difficult for care providers to plan and respond effectively.

   - **Example:** A client was admitted with a suspected stroke early on a Saturday and discharged the same evening without any contact with the care provider. The client had no medication or care visits until they called the office themselves on Monday morning.

2. **Unsafe Discharges**

   Clients are sometimes sent home without notifying care providers, leading to serious risks.

   - **Example:** Clients have been dropped off at home without access, and care providers were asked to give key safe codes over the phone - something they cannot do for safety reasons. In some cases, clients were left outside without support.

3. **Medication Management Issues**

   Discharges often involve outdated prescriptions or changes that aren't communicated properly, leading to missed doses and urgent rota changes.

   - **Example:** A client was discharged with a change in medication frequency from 3 to 5 times a day. The first dose was missed because only a few carers were trained to administer it, requiring urgent rota changes that disrupted care for other clients.

4. **Transport Concerns**

   Clients are sometimes sent home in taxis without checking if they have access to their home or support waiting.

- **Example:** Transport is arranged without confirming whether the client has a key or someone to meet them, which can leave vulnerable people at risk.

5. **Technology and System Integration Gaps**

   Providers want better digital systems to flag patients with care packages and share updates, but data protection rules (GDPR) are a barrier.

   - **Example:** Providers often don't know a client has been admitted or discharged until the client or family contacts them. A shared care record would help, but current systems don't allow this level of integration.

6. **Family Communication Gaps**

   Families often turn to care providers for updates when they can't get through to the hospital, but providers are limited in what they can share.

   - **Example:** Care providers are frequently contacted by worried relatives, but due to data protection, they can't always provide the answers families need.

Summary

Feedback from residential and domiciliary care providers across Redcar & Cleveland and Middlesbrough shows that while there are examples of good practice, hospital discharge processes are often inconsistent and difficult to manage.

Providers shared concerns about poor communication, last-minute discharges, and medication issues, which can lead to missed visits, safeguarding risks, and stress for staff. However, there are clear opportunities to improve—such as better coordination between services, using shared digital records, and recognising care providers as key partners in discharge planning.

With more joined-up working and clearer processes, we can make hospital discharge safer, smoother, and more supportive for everyone involved.

Suggested recommendations

- Always contact the care provider before a person is discharged to confirm support is in place and access to the home is available.
- Use a Standard Discharge Summary
  Provide a clear, easy-to-read summary that highlights key changes in care needs, medication, and any follow-up actions.
- Respect and Use Hospital Passports
  Refer to the hospital passport or care plan provided by the care setting to understand the person's needs and ensure continuity of care.
- Improve Medication Handover
  Ensure medication changes are clearly explained and that a full supply is sent home with the person to avoid missed doses.
- Coordinate Transport and Access
  Confirm that someone is available to receive the person at home or in the care setting, and avoid leaving people without support.
- Create a Discharge Liaison Role
  Assign a named contact or team to coordinate discharges and act as a point of contact for care providers and families.
- Invest in Shared Digital Systems
  Work towards a shared care record that flags patients with care packages and allows safe, timely information sharing.
- Recognise Care Providers as Partners
  Involve care providers in discharge planning and decision-making—they know the person best and can help ensure a safe return.

Response to Recommendations

Stephen McKenna, Head of Nursing Patient Flow at South Tees Hospitals NHS Trust, shared an update on actions that have been completed or are currently underway in response to the recommendations outlined in our report.

- Always contact the care provider.
  On our EPR system we have a new discharge checklist for all patients leaving hospital, this checklist includes contacting the care providers. From an assurance perspective we have a data reporting system in place to measure compliance with this care plan.

- Use a Standard Discharge Summary
  There is a working group, which includes ICB colleagues, to review a discharge summary which can be emailed directly to the ongoing care providers.

- Respect and use hospital passports
  One of our key patient safety messages to staff is to ensure that hospital passports are requested and utilised on and during the patient's admission to hospital.

- Improve medication handover
  We have worked with colleagues in Pharmacy with regard to new medications and the communication of this to care providers. The prescription is now added to the Electronic Patient Record (EPR) system to allow the ward staff to view what has been dispensed. This is also included in the discharge checklist.

- Coordinate transport and access
  This has been included in the discharge checklist to ensure that the person at home receiving the patient is aware of the discharge arrangements.

- Create a discharge liaison role

For patients with complex discharge arrangements who are going to care homes, a staff member from our transfer of care hub is allocated to the patient to coordinate the discharge process. We appreciate that staff may change in light of annual leave. Where able we do try to avoid allocation of a patient when team members are approaching annual leave. However, patient complexities change resulting in handover of case worker.

- Invest in shared digital systems
  When patients are admitted to hospital from care facilities this information is added to our EPR system, as a flag. However, current legislation does not permit the integrated care system sharing of information with care providers, this would be regarded as an information governance (IG) breach.

- Recognise care providers as partners
  We have been to the Redcar & Cleveland and Middlesbrough care home forums (invited by Paula Briggs ICB) and we meet monthly to review cases of admission avoidance from care providers through the support of the Hospital at Home service.

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Healthwatch Middlesbrough & Healthwatch Redcar and Cleveland
Thorntree Community Hub and Library
Birkhall Road
Middlesbrough
TS3 9JW

www.healthwatchmiddlesbrough.co.uk
www.healthwatchredcarandcleveland.co.uk
t: 0800 118 1691
e: healthwatchsouthtees@pcp.uk.net