Your voice counts

Experiences of hospital discharge in Sheffield

healthwatch Sheffield

July 2026

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Background

What is hospital discharge?

Hospital discharge[1] is the process of leaving hospital once you no longer require hospital care. It includes planning for what happens next.

Once you're admitted to hospital your treatment plan, including details for discharge from hospital, should be developed and discussed with you. A discharge assessment will determine whether you need more care after you leave hospital. For instance you might need:

- Short-term help like a series of visits from carers
- Longer-term help like ongoing visits from carers, or moving into a residential care or nursing home
- Existing care visits being increased, either temporarily or permanently
- Aids and adaptations to help you to navigate around your home or neighbourhood

You might not need any extra care putting in place and be able to go straight home – whether this is to your own home or to a social care setting that you already live in.

You should be fully involved in the assessment process, and with your permission family or carers should also be able to contribute.

Why did we do this work?

We know that there are ongoing city- and organisation-wide conversations about improving the experience of hospital discharge.

[1] https://www.nhs.uk/nhs-services/hospitals/going-into-hospital/being-discharged-from-hospital/

While visiting care homes and Extra Care settings, we recognised an opportunity to ensure that these residents' views and experiences were explored as part of those workstreams.

We spoke with Sheffield Teaching Hospitals and Sheffield City Council about the questions we wanted to ask people, to ensure that the findings would be helpful for the improvement work that they're doing.

What did we do?

Between January and April 2026 we visited six residential living facilities - one care home and five Extra Care housing schemes. Extra Care[2] is a type of housing which means you live independently but there are staff who can help provide personal care and support services.

We spoke to 29 people about 31 experiences of discharge from inpatient hospital care - some people had had more than one recent hospital stay. We mostly spoke directly with the people who had been in hospital; 3 of the people we spoke to were family carers.

In Sheffield around half of patients are discharged home from hospital without any specific additional support (known as Pathway 0), while the other half need some support putting in place (known as Pathways 1-3 depending on the level of support needed). The people we spoke to were mostly split between Pathway 0 and Pathway 1 – people needing short-term support.

They were admitted to hospital for a range of reasons, including long term conditions as well as falls and injuries. Some people will have had to pay for the care they received when leaving hospital.

We carried out short interviews with these residents/carers where we asked about:

- How discharge plans were made:
    - Their involvement in decisions and discussions about their treatment and discharge
    - Information they were given about their care after discharge
- Their experiences of discharge:
    - Their experience of discharge from hospital back into a residential living facility
    - Their experience of care following their hospital stay

[2] https://www.ageuk.org.uk/information-advice/care/housing-options/assisted-living-and-extra-care-housing/

Findings

Summary of key findings:

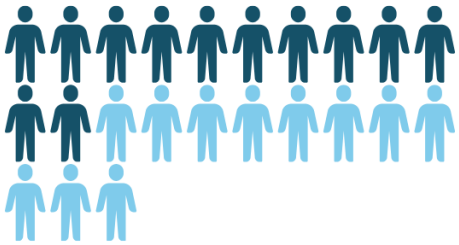
- Most people felt extremely positively about the care they received while in hospital, as well as the support they receive from their care home/Extra Care setting and their GP.
- There was a great deal of inconsistency in whether people felt involved in discussions and decision-making, both in relation to their care and treatment, and the discharge process.
- People weren't consistently informed about what was going to happen after they left hospital.
- People whose families/carers could be involved, take an active part in decision-making, and advocate for them if necessary, generally had a better experience than those who didn't.
- For people who were being discharged back to a care setting they already lived in, there could be additional confusion around what care was being put in place directly due to their stay in hospital; this does not help to empower people to play an active role in their own care.

Involvement in treatment and discharge planning

Involvement in decisions about discharge from hospital, care, and future placement

23 people told us about how involved they felt in decisions about their care and their discharge from hospital.

There was an even split here, with 12 people saying they felt involved, and 11 saying they didn't.



Around half of people said they felt involved in decision-making

Everyone who felt they were involved in these decisions was pleased about this:

> "I felt involved, the staff talked to me about my discharge and what would happen. They talked about the short term support I would get at home"

> "They asked about the treatment plan and asked if am happy with it"

Some people who said they weren't involved in decision-making felt the medical staff were making the right decisions and acting in their best interests:

> "I wasn't involved but I feel like they have been very good and made the right decisions"

> "They just decided when I was fit to go home [….] The discharge was ok, no complaints"

However others were very unhappy about their lack of involvement – they had a strong wish to be consulted about their treatment and discharge plan:

> "Not at all, didn't understand what was happening to me as I was very unwell. I wish they would have discussed it with me"

> "Not involved - I was discharged 3:30am in the morning – I was very annoyed about this"

Involvement of family or carers in discussions about leaving hospital

Not everyone had family or carers they could involve in these decisions, while others didn't want their family to be involved due to complex relationships or preferring to be independent.

Some people's families/carers were very involved in discussions and decision-making. For some patients, this was helpful because they didn't feel able to fully participate in those discussions themselves. For others, it was helpful to make sure that family members who'd be helping to look after them fully understood what was happening. Generally the people who said their family were very involved described a more positive experience of discharge from hospital and subsequent care.

> "My son was involved, staff talked to him about the discharge date and time so he could arrange transport for me to get home"

> "My brother is very involved and done everything"

Other families/carers were kept up to date about developments – either by the hospital or by the patient – but were not actively involved in discussions or decision making.

We only heard a few experiences of family who wanted to be involved who were not kept informed at all. However this had a big impact on the patient's experience – their overall descriptions of discharge and follow-on care were more negative.

> "Son was getting frustrated with lack of communication from hospital. Had to update son herself [...] Was given hospital carers after son had pursued it with them repeatedly. He had to chase quite a bit. Son took over this as the process was making her quite upset"

> "[Relative] had to ring hospital repeatedly get answers with regards to post-discharge care"

Some people reflected on the difference it made having family who could be actively involved in their care planning:

> "I wonder what happens with other people that don't have anybody to advocate for them, because there's heavy reliance on family"

Preferences about care and treatment being respected

Where people had shared preferences relating to their care while in hospital, or their treatment plan, nearly everyone said these had been respected:

> "Preference not to have male nurses for private care eg shower were respected"

> "She's not sure if her own decision was right, as she refused treatment (chemo). Feels alright at the moment. Will have treatment when the time is right."

Where preferences weren't or couldn't be met, this had a big emotional impact on people:

> "I was bed bound and I needed a toilet but they wouldn't let me and I had to use a commode which was upsetting, demeaning and embarrassing because I had to use it behind the curtains and everyone could hear it"

What happens when patients and their families feel involved and respected?

Janet* spent time in hospital for cancer treatment. She was very pleased with the way she was treated while she was there – "you could tell they really cared".

She felt very involved in decisions about her treatment plan and her discharge home from hospital, and staff involved her husband and other relatives too as they would be helping to look after her when she returned to her Extra Care housing. Staff explained the details of the care she would receive once she left, including scans and blood tests, and gave Janet written information about her diagnosis and the medication she was being prescribed. She was also given a card with important contact details on it, which she could keep in her purse. This was all presented in a way she found easy to understand.

When it was time to go home, she was told the day before, which felt like enough notice for her. There was some delay while waiting for medication but this was explained well and it did not cause too much disruption.

Janet's diagnosis is terminal, but her positive experience in hospital and her involvement in decision-making has made her feel confident in the ongoing treatment she's receiving.

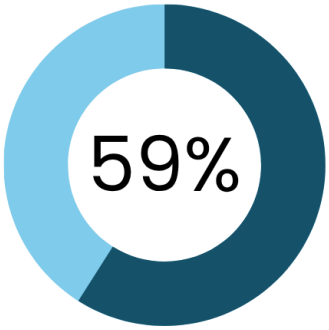
**Name has been changed*

Information about care after discharge

Knowing what was going to happen next with your care

People reported mixed views as to whether they knew what was going to happen next with their care, yet this had a big impact on how they felt about their overall experience. 22 people told us whether they knew what would happen next – 13 people did, while 9 didn't.

When people felt confident in what was going to happen next, this was overwhelmingly viewed as positive and provided some certainty at what can be a difficult time:



A little over half of the people we spoke to felt that before leaving hospital they knew what would happen next with their care

> "Knew who was coming out. COPD nurses, rehab nurses and physiotherapists"

> "I knew I would be getting short term help at home and when they came they were great. Helped me to get back on my feet. Helped with meals, having a wash"

> "It was for my husband and they knew that I would be looking after him. They also arranged for some carers to come and help. They come three times a day to support him and myself"

Others didn't know what was going to happen next – this was unhelpful as it made people feel worried, uncertain, or forgotten about:

> "It wasn't discussed, felt like discussions were made around me but not with me"

> "Didn't tell me anything. I just got a letter after a couple of weeks. Once you get to our age they fob you off"

In some cases it meant that care people felt they needed wasn't put in place at all:

> "I just got told I was going home, I needed a care plan in place for when I got out but nothing happened"

> "Things didn't happen the way they should have. They said things were in place but they weren't. I feel they are not confident in the process themselves. I understand they are very busy and short staffed but it is just not right"

What happens when communication doesn't work well?

Sandra* was in hospital for about three weeks. She wasn't happy with her experience of care while there – she felt it was understaffed, and patients were made to feel "neglected" as a result. She told us it sometimes took 40 minutes for someone to come and help her use the commode, and other requests were forgotten about.

She had had carers before she went into hospital, but her son had to repeatedly chase the hospital to get this support put back in place before she was discharged. The difficulties her son had in trying to communicate with the hospital,

both about her discharge and her post-discharge care, caused both of them a lot of stress.

When a doctor eventually told her she was ready to be discharged, and a care package and equipment had been put in place at home for her, this wasn't communicated with the rest of her care team in hospital and she didn't end up going home until three days later.

She was happy with the written information she was given about her condition, and didn't need any medication changes, but found the rest of the experience "upsetting" and as though she was not in control. She's not sure how she would have managed without her son chasing things up on her behalf.

**Name has been changed*

What kind of information were people given about their care after discharge?

Some people felt fully informed and had written information provided to them, while others felt they were discharged with no clear idea about what would happened next.

1. Additional equipment or home adaptations:

Many people already had the equipment or home adaptations that they needed, but eight people told us about new arrangements that were put in place for them. They were largely pleased with how this was arranged, though in some cases waiting for items to be delivered and set up at home did cause delays to their discharge:

> "Knew that a team would come out to see me after to discuss fitting handrails, and providing Zimmer frame and walker"

> "They gave me a specialist chair and spoke about it. They asked me if I wanted it"

> "The occupational therapist team were more involved and very helpful compared to the hospital"

Some people said equipment or adaptations weren't discussed in hospital, but nobody felt that they missed out on something essential. There was reasonable confidence that if they'd needed something, the discussion would have come up.

2. Further health or social care services:

Just under half of the people we spoke to told us they didn't need further services when they were discharged from hospital.

Of the remaining residents, there was an even split between those who told us a discussion took place and they were able to talk about their future needs and getting services in place, and those who told us that no discussion took place at all. Many of these people weren't sure if they needed future care or not.

3. Information about new medicines or changes to medicines:

20 people told us they had been given new medicines, or their medicines had been adjusted while in hospital. A small majority (12) said they were given good information about this. Written information they could keep was seen as particularly helpful:

> "Was given a card with all medicines on, no issues"

> "I was given a list of all the medication and some documents with information"

The rest (8 people) were given new medication or had old medication taken away and didn't feel this had been explained properly. They found this confusing:

> "They took my meds off me without explaining"

> "They just gave me the tablets. They didn't read the label or instructions, I had to read it myself"

> "He makes mistakes with tablets. They look the same. They just explained what was wrong with him"

> "Changes were made to insulin. He didn't understand that the nurses were going to start him off so low. He thought it was too low but he didn't know the exact treatment he was getting until after"

4. Information about what you should or should not do after leaving hospital:

Some people were given good written information (or verbal when they'd specifically requested this):

> "They were very good at explaining, they were very good with us. They provided a lot of information and a leaflet with some information. They also mentioned that there would be some follow-ups with the GP"

> "They gave me written information about not lifting things, not to drive for a week, a sheet with arm exercise instructions that I had to follow, to tell the DVLA and to send them a copy of my discharge notes"

Others felt they weren't told anything or were given information they didn't understand. In some cases this led to them being surprised by follow up care that had been put in place:

> "No information. Team from adult psychiatric team came out to see me after. It was a surprise to me. I was not expecting them"

> "They didn't give me any information"

5. Knowing who to contact after leaving hospital

Most people were told by staff who to contact if they were worried about anything after their discharge from hospital. This information was of variable quality and consistency – some was very thorough:

> "They gave me a plastic card with contact details which I put in my wallet and said that if I had any pain or anything I could ring the numbers on there"

> "I have the phone numbers, they got me a document with all the phone numbers that I have with me everywhere"

Some were given basic verbal advice:

> "Just [told] to ring the doctors but no specific information"

A few people told us they weren't given any information about who they could contact if they had concerns.

Experiences of discharge from hospital

Having enough notice of discharge

Most people (15 out of the 20 who spoke to us about this) felt they were given enough notice about when they would be discharged from hospital.

How much notice was 'enough' was very subjective – the answers from

Three quarters of people felt they were given enough notice about when they'd be discharged

people who felt they'd had enough notice ranged from a matter of hours to one week.

Meanwhile, the answers from people who felt they hadn't had enough notice ranged from no notice at all to less than 24 hours.

Where there is crossover here, the difference in people's experiences seems to be in whether the person themselves felt ready to go home – in terms of having support to physically travel home, having equipment in place at home waiting, or having a care plan in place:

> "Given a good couple of hours, I feel that was enough"
>
> "I had about 3 days' notice but they confirmed it in the morning. I think it was enough notice"
>
> "The night before. It was not enough notice. I had to phone the district nurses up. It was too vague. The nurses in hospital still had to follow up with the mattress as it had not arrived yet"
>
> "The arrangements changed at the last minute which caused all the problems"

Most people hadn't experienced significant delays to their discharge. Some were delayed (up to several hours) waiting for medication or for a taxi to arrive, but the cause for the delay was generally explained to them. How long the delay was likely to be tended to be less well explained, however most didn't feel this had a significant negative impact. We did hear one case where miscommunication around discharge planning caused significant frustration:

> "Despite being promised on the Wednesday morning by the doctor, the nurses/staff never got the message and no one communicated with her so each subsequent day passed with no change. Wasn't discharged until the Saturday"

Discharge preferences and needs being met

While people were generally happy with how their care preferences were met while in hospital, they were less likely to feel as though their preferences for being discharged from hospital were met. Some people still had a positive experience here:

> "I asked them to wait for my son to come before I could leave the hospital and they waited for him"

> "I spoke about my preferences of how I was going to get home. I wanted my daughter to pick me up and there were no problems with it"

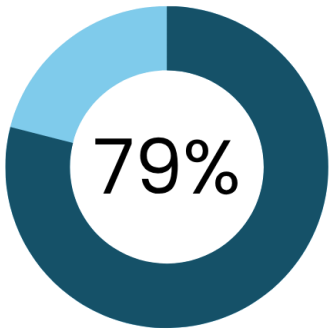
Where people were less happy, this was often because they weren't fully involved in discussions and didn't feel their preferences had been heard. However we recognise that some people will have wanted to leave hospital before they were deemed medically fit to do so.

A few people told us they were supposed to be met by staff when they arrived home, but this handover didn't happen. Some of these experiences were distressing due to lack of communication and worries about safety:

> "They need to involve the family in the decisions like the date of discharge rather than just the care company to make sure that you are there to feel like his needs are well taken care of. There was lack of communication between the care company and the hospital. He was just left on his own in the flat. The ambulance service was meant to hand him over to [staff] but that didn't happen which was really distressing. Both sides should be clear about what the procedures are. His wheelchair got stuck in the skirting board and he didn't know what to do."

Experiences of care after hospital

People generally felt very positive about their experiences of care after being discharged from hospital. 19 out of the 24 people who told us about this felt they were well supported.



79% of the people we spoke to felt they'd had enough support after being discharged from hospital

It is important to remember that the people we spoke to all lived in care homes or Extra Care housing, with staff who could support them with daily activities or check on them regularly. This is the type of care that some people mentioned, rather than support that was put in place specifically as a result of their hospital stay:

> "The staff here at [my accommodation] came into my flat to check on me every other day"

> "I have had lots of support here, nothing could be done better, it's all been very good"

Many weren't sure whether the care they received was due to their hospital stay or not. This suggests that there might be additional considerations for hospital or Adult Social Care staff when someone is being discharged home to a care setting, in making sure they understand what to expect.

We did hear some positive examples of support that came from a discharge assessment:

> "I got support from the short-term team. They helped me at home with meals and washing"
>
> "Currently gets hospital care 4 times a day, strictly for own wellbeing (ie not for household chores). Has a very good experience with them – finds them to be very nice and has a laugh with them"
>
> "A lot of support, the physio has been to see me, regular blood pressure checks"

A few felt they were left with no support after leaving hospital, either through care put in place via a discharge assessment, or from the staff at their Extra Care accommodation. Again, we heard concerns for those who don't have family and rely only on staff:

> "Sometimes when dropped off on my own no body is here at all"
>
> "Not really, if it wasn't for family, things would have been a lot worse which must be even harder for people that don't have any family to support and advocate for them"

A spotlight on S2A beds

When starting this work, we planned to visit more care homes and nursing homes with S2A beds (Somewhere else to Assess). This is a discharge pathway used when someone no longer needs to be in hospital, but needs further assessment to determine what should happen next with their care before returning home or moving in elsewhere.

However, we found that a large proportion of patients in S2A beds had dementia; care home staff told us that due to those symptoms as well as the reasons they'd been in hospital, they were not able to participate in interviews. We are concerned that this means people living with dementia don't have a voice in work to improve services. It is important therefore that when working to improve people's

experiences of discharge, health and social care services need to ensure this group's views can be heard in a different way.

We did speak with two people who had previously lived in their own homes, and had been discharged from hospital into S2A beds in a care home. Neither felt involved in discussions or decision-making about their care and future plans.

Paul's story

Paul* didn't know much about his care, but he felt positively about his experience. He told us he had a family member who was very involved, and spoke with staff about what would happen when he was ready to leave hospital. Paul wasn't involved in any of these discussions, but felt confident that the right decisions were being made on his behalf.

He didn't know what was going to happen next – though he presumed the plan was to go home at some point – and he didn't have any written information about his care. He took the medication which was brought to him by carers.

However, he felt safe and confident that care home staff were supporting him - "I have had lots of good support here, nothing could have been done better" - and that his relative was looking out for his best interests.

Eddie's story

The other person we spoke to was far less happy about their experience. Eddie* wasn't kept informed about what would happen when he left hospital, and wished he had been. Staff had communicated with his wife but not included him in discussions. He assumed his stay in the care home would be temporary, but he didn't know how long it will be and he had already been there for several months.

He said he had no written care plan and took the medication which was brought to him by carers. It took two months for a social worker to visit and speak to him, but that didn't result in a plan for future care being communicated either.

Eddie told us it "feels like being in jail" – he felt safe but said he wasn't receiving much care or treatment beyond having his medication brought to him, and he wasn't allowed to go for walks due to staffing levels. He didn't understand why he couldn't go home and be looked after by family, and was frustrated that decisions were being made without his involvement or even informing him.

**Names have been changed*

Feedback from residents about other health and social care services they've used

Feeling safe and well cared for

We heard overwhelmingly that people felt safe and well cared for in their current home. Nearly everyone expressed positive sentiments about their care or the staff who supported them:

> "We have red strings in the room that we can press if we need anything and staff [here] answer straight away. I also have a button on me around my neck that I can press in case I have an emergency like a fall"

> "They are lovely, the carers are great"

We only heard a few negative experiences:

> "When I ask for help they say they are busy. When I press the button, they don't come up"

Care from GP practices

We also heard a great deal of positive feedback about people's regular GP practices – who supported them both before and after their stay in hospital. These included:

- Norwood Medical Centre
- Norfolk Park Medical Practice
- Woodhouse Medical Practice
- Flowers Health Centre
- Southey Green Medical Centre
- Meadowgreen Health Centre

People spoke about their GP going "above and beyond" for them:

> "They are always doing their best and give us the support that we need"

> "Excellent medical centre. You read about people waiting weeks for appointments but at this GP, you get same day appointments"

> "They are excellent. They actually come to my flat and see me which makes a big difference"

Conclusion and next steps

Based on the experiences people shared with us, it seems clear that patients are not having a consistent experience of hospital discharge. Features of good practice include:

- Involving the patient and – where possible – family/carers in decisions about care and discharge
- Ensuring patients understand the information they are given about their treatment, both in hospital and afterwards

These principles are already embedded in discharge policies and procedures, but not everyone is experiencing this, so a focus on improving consistency of approach is needed. In July 2026 - after we completed this work - NHS England published guidance on the model discharge pathway[3], where they emphasise the importance of timely discharge, meaningful patient and carer involvement in decision-making, and clear and transparent information. Some of their key findings mirror our own – that "while the components of good discharge are well understood, they are not applied consistently".

We will be sharing this briefing with those in the health and care system locally – particularly Sheffield Teaching Hospitals NHS Foundation Trust and Sheffield City Council – who are working on improving experiences of hospital discharge for people in Sheffield. Alongside embedding principles from the new NHS England guidance, they could consider the following questions:

- Where people are being discharged back to a care setting they already live in, how can we provide extra clarity around who will be providing ongoing care?
- When people don't have family/carers who can be involved in their care, how can we make sure we're understanding and improving their experience?
- How can we ensure we're hearing from people living with dementia, and understanding and improving their experience?

Embedding feedback mechanisms at different points in people's end-to-end experience (from being admitted to hospital through to being back at home after their hospital stay) will be an important part of this.

[3] https://www.england.nhs.uk/publication/model-discharge-pathway/