



People's Experiences of Leaving Hospital in Blackburn with Darwen

March 2026

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About Healthwatch Blackburn with Darwen

Healthwatch was established under the Health and Social Care Act 2012 as an independent consumer champion to understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf.

There are over 150 local Healthwatch across England. The role of a local Healthwatch is to:

- Listen to people, especially those who are most vulnerable, to understand their experiences and what matters most to them.
- Influence those who have the power to change services so that they better meet people's needs now and into the future.
- Empower and inform people to get the most from their health and social care services and encourage other organisations to do the same.

Find out more at: <http://www.healthwatchblackburnwithdarwen.co.uk>

Background

A key focus of both East Lancashire Hospitals Trust and Blackburn with Darwen Borough Council in 2025/26 has been a safe and timely discharge to home with support from Adult Social Care or to a temporary care setting through the 'Discharge to Assess' pathway in order to reduce the number of residents being discharged to care homes on a permanent basis.

In addition to this, the Council and the Trust are working to establish an Enablement Hub which will support transfers of care from the hospital through multi-agency collaboration within discharge planning and support with identifying the best community support and treatment for people at risk of avoidable hospital admission. The aim is to ensure that residents receive a timely response that links them to forms of support that are strength-based, proportionate and effective.

Methodology

We developed a survey for residents to complete which was shared both in person and online with support from Darwen Primary Care Network. The survey asked residents for feedback on their experience of complex hospital discharge, either as an individual or as a carer, to home or other settings with support from adult social care in the last 6-12 months.

We received 111 responses to the survey. The findings are detailed in this report.

Further exploration

We had hoped to visit Albion Mill, the intermediate care scheme in Blackburn with Darwen, as part of this project, however due to operational changes at the facility this has not been possible. However, we would still wish to visit Albion Mill to gather patients' experience of the step-down support following discharge from hospital.

The responses were predominantly from residents of a White British background therefore further targeted engagement with other communities in the borough would be beneficial to understand whether there are any differences in sentiment about support received.



Executive Summary and Recommendations

Planning for Discharge

Overall, residents' experiences of planning for hospital discharge, either as the patient or as a carer, are not consistent, ranging from very good to poor.

Whilst some patients experienced effective communication and support at the point of discharge, this varied a great deal. Two thirds of carers did not feel that their needs as carers were taken into consideration as part of the discharge planning process. The wider needs of vulnerable adults were also not always considered as part of the discharge process.

Most patients felt that they were ready to leave hospital at the point of discharge, however some were not due to either their home situation or care package not yet put in place.

A third of respondents felt that, where their loved one did not have capacity or had fluctuating capacity, actions were not necessarily taken in the best interests of the individual. Carers felt that their loved one's ability to cope when home was not fully considered in the discharge planning process.

The majority of respondents, however, felt that they were discharged to the best place for their recovery.

The discharge process

70% of respondents felt that the discharge process went smoothly and that they were informed of the time and date of their discharge. However, some patients experienced rushed last-minute discharges from hospital.

Most patients had a package of care on a timely basis, however those who did not felt that they had to push for support.

Experience of recovery setting

Overriding feedback from respondents was that the setting to which they were discharged was most appropriate for their needs and the majority of respondents were happy with the care received.

Most people felt that they were supported to regain their independence, however those who did not, felt isolated with lack of support and some experienced delays in provision of equipment and adaptations to their home.

Some felt that when they were discharged to a bedded setting that it was not always easy for loved ones to visit and some respondents did not feel involved in financial decisions regarding their or their loved one's ongoing care. However, the majority of respondents did feel that they had been provided with appropriate information for next steps once the package of care ended.

Recommendations

Hospital discharge planning recommendations

- East Lancashire Hospitals Trust and BwD Adult Social Care should both ensure both patient and carer active involvement in their discharge planning through a multi-disciplinary team approach, including plans, preferences, timescales and any concerns.
- A multi-disciplinary team approach should be used to ensure the planning process is well-communicated and minimises the risk of oversights.
- Steps should be taken to ensure and improve readiness for discharge: with clear protocols to assess patients' readiness for discharge, ensuring they feel prepared and well enough to leave the hospital.
- Carers' needs should be central to the discharge planning process as part of the assessment of readiness for discharge.

General recommendations

The report has highlighted some gaps in joined-up care and poor communication.

- Strengthen communication across all settings, improve communication between health and social care providers, patients, and their families to ensure clarity and understanding of the discharge process, follow on care and available support services.
- Improve recognition and understanding of unpaid carers' role and capacity to provide care and involve carers in financial decisions relating to their loved one's ongoing care.



Findings from the survey

Planning for Discharge

Did you feel involved in the discharge planning for you/your loved one?

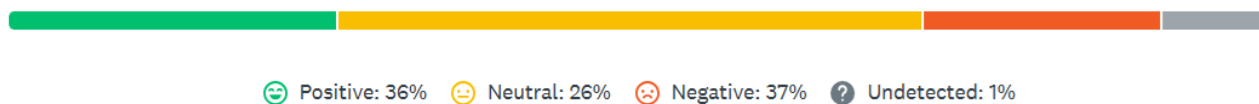


Although the majority of people stated that they did feel involved in the discharge planning, 39% of respondents stated that they did not.

Please give details of your experience

The sentiment analysis of people's responses is shown below, with positive and negative experiences at similar levels.

How people feel:



Positive experiences by respondents included: -

"Told by the doctor what pain relief and supports I would be given to go home with and discussed the help planned by my family."

"Stepped down to Albion Mill and had a good rehabilitation from the staff."

"I received a follow up from IHSS on returning home which was excellent."

"The hospital ensured my husband was fit to be sent home, and OT ensured we had any required equipment."

"Both myself and my husband have been hospitalised recently for cancer. Fully supported throughout and on discharge."

"I was informed of what would happen after my wife was discharged from Clitheroe Community Hospital and about the carers that would visit twice daily to see to her needs."

"My experience was very good, and I felt confident in my care."

Neutral feedback included the following: -

"We had a meeting with social workers to discuss it."

"I was not aware of any discharge planning until I arrived home and received a phone call about home visits for physiotherapy."

"Told me that I will have extra care when I left."

"Constant dialogue with the discharge department."

"Explained to me that I was being transferred to Albion Mill that night and would be going home tomorrow."

"No after support ever offered."

Negative feedback included the following statements from respondents: -

"Although it was discussed, my complex needs were not really considered. Things were organised without my consent; it was only when I was told by someone helping me that I said that I didn't want it to happen. It was cancelled. They are discharging me without me being able to manage the 15 stairs adequately. They are talking to me about how I might be able to have something put into the flat, but I can't remember but they are not discussing it with my relatives, so they don't know what's happening either."

"We were spoken to about where the patient would go on discharge which was to her daughters so she could get the help and support she needed. However, the hospital did not complete a TAD which they said would be done."

"No one spoke to me about my wife coming home. Or what help she would need what she would need."

“The discharge was an instruction without consultation.”

“I could never get a straight answer when my husband was going to be discharged. When you spoke to hospital staff every member gave you a different answer. Communication was terrible.”

“Waited all day for pharmacy and when antibiotics did arrive, I was issued with 1 tablet. Had to go back the next day to collect the remainder of the course.”

“Staff in OPU (Older Persons’ Unit) were not very keen to share details even though it was myself who needed to know more information so as to enable me to make the necessary arrangements. Very disappointing stay in a ward where patients were treated as though they were incapable of comprehending any information given. An insult to mentally able patients.”

“No... I thought that the hospital made the discharge decision without seeing if the appropriate equipment was in place or indeed if I was ready, in great wellbeing, to cope and that my support was in place too.”

“There didn’t seem to be any after care put in place.”



The majority, 84 respondents, felt that they were ready for discharge, however 22 respondents stated they were not.

If not, why not?

Responses from people who did not feel ready to leave hospital at the point of discharge included: -

"My daughter in law who went with me told the specialist that we were just going round in circles at which point he offered to refer me to rheumatology, but I haven't heard anything since."

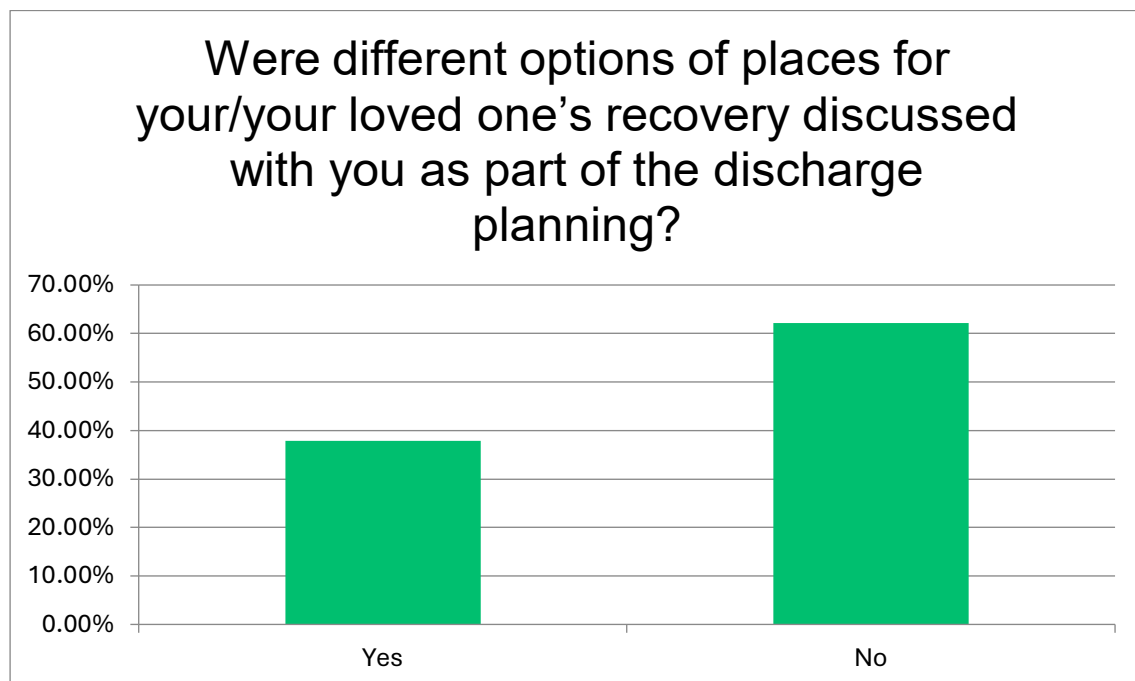
"Mainly because we/she hadn't been given time to organise her home situation."

"Symptoms still present."

"Too frail breast cancer stage 4 SEN needs."

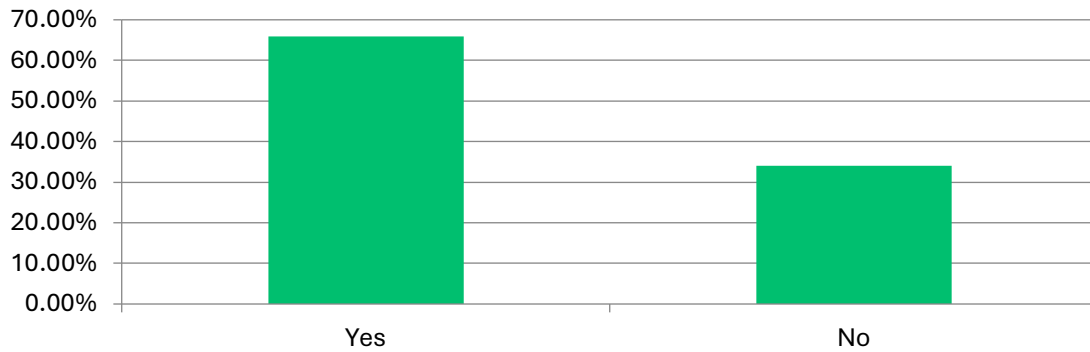
"Again, the equipment, care package etc had not been finalised or discussed so that I had that clear expectation, clarity on my accountability and my responsibility in the care at home."

"Yes, for my husband. He's so keen on coming to home. But for me, to be honest NO. I'm not a medical professional. I just don't know what to do if something happens to him next time. I really wish he could stay in the hospital longer."



Whilst the majority of responses were no to this question, not all respondents required an alternative to home on discharge from hospital.

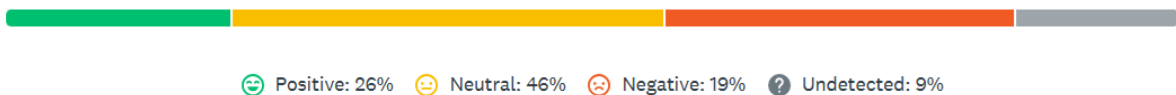
If you or your loved one did not have capacity or had fluctuating capacity, do you feel that the discharge plans were made in your/their best interests and in an appropriate timescale?



62 respondents felt that the discharge plans were appropriate whilst 32 respondents did not feel that they were made in the best interests of them/their loved one who either did not have capacity or had fluctuating capacity.

Please expand on your answer to question 6

How people feel:



Positive feedback included: -

“The medical staff were excellent & went through step by step what would happen.”

“Yes, I was provided with options and details regarding each one.”

“Home first was brilliant. I received help washing and with any physical aids I needed. Fantastic”

“Was told that carers would be provided morning and night. All necessary equipment was provided including a hospital bed because I couldn't go upstairs.”

“Told me his wife and carer what had to happen.”

Neutral feedback included: -

"I had POA but felt as if I wasn't listened too."

"Social workers found a place for my husband in Thorncliffe as he has a stroke, and I couldn't care for him at home."

"All concerns were taken into consideration on discharge."

"The doctor discussed my situation at home and if I would be on my own if I had any help."

"About carers and physio also medication and contacts."

"The process was a bit complicated and outside my control."

Negative feedback from respondents included: -

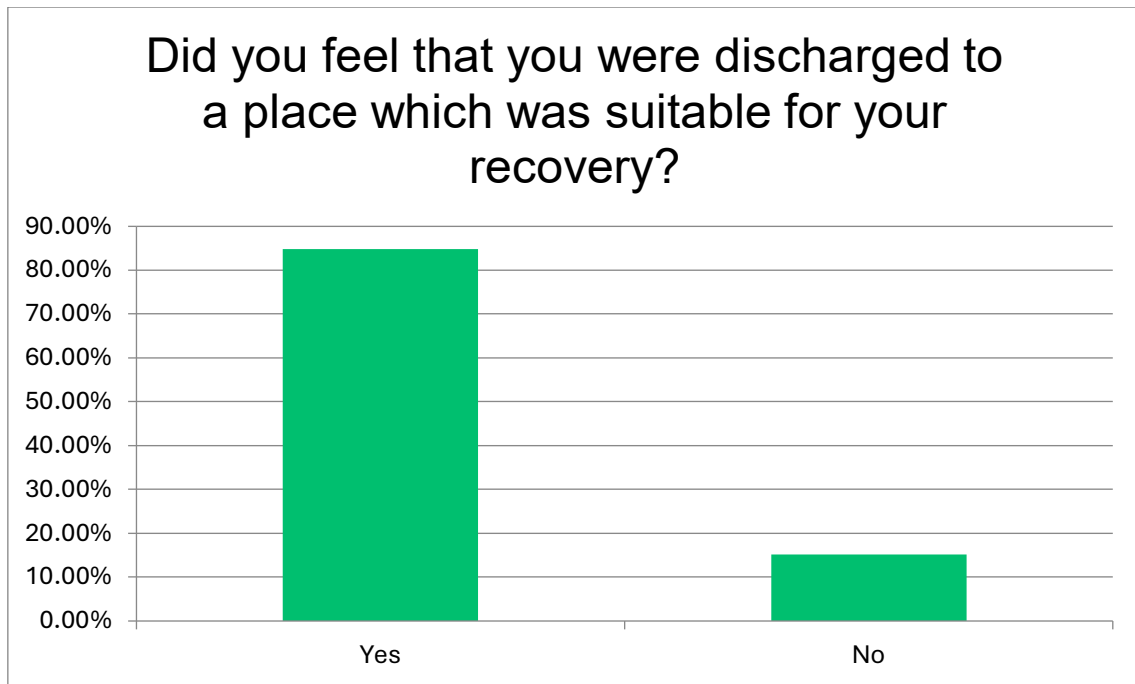
"No one spoke to us."

"Zero input from anyone as regards managing once home."

"Discharged because able to walk with a frame, no back up as to personal care or how I could cook and take food from kitchen to a seating position to eat."

"My ex-wife lives on her own, her mental health wasn't at its best and combined with her other health problems I don't think it was safe at the time for her to have been discharged."

"No... as when dealing with end of life, non-verbal cared for... the whole decision-making process wasn't discussed as to what additional support, equipment and care benefits I needed to provide best care for my loved one and indeed what coping support was there for my wellbeing as a carer."



The majority of respondents felt that they were discharged to the most appropriate place with only 16 respondents stating that they were not.

Please expand on your answer

Positive feedback included: -

"Home was the best place for recovery."

"Discharged to Albion Mill fantastic facilities."

"Because our patient felt comfortable at home and his condition was not bad."

"I went home after some physio and was looked after very well by my husband."

"One night at Albion Mill and then home which I was happy with."

"Going home to extra care home."

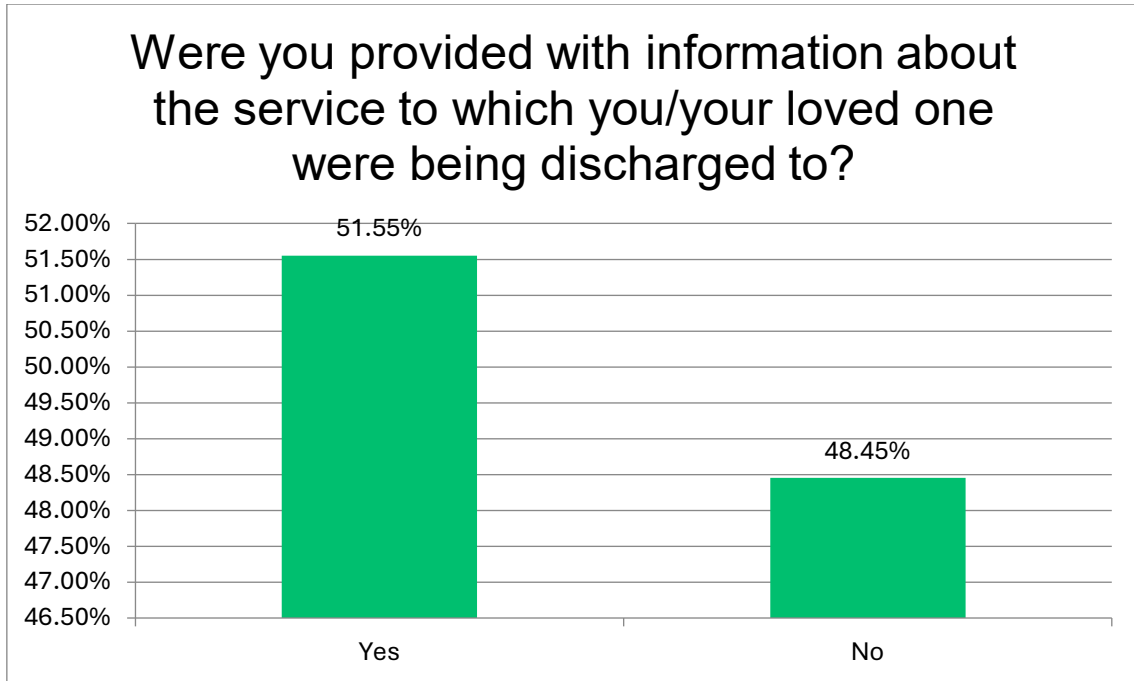
Negative feedback included: -

"My wife was sent home with no help."

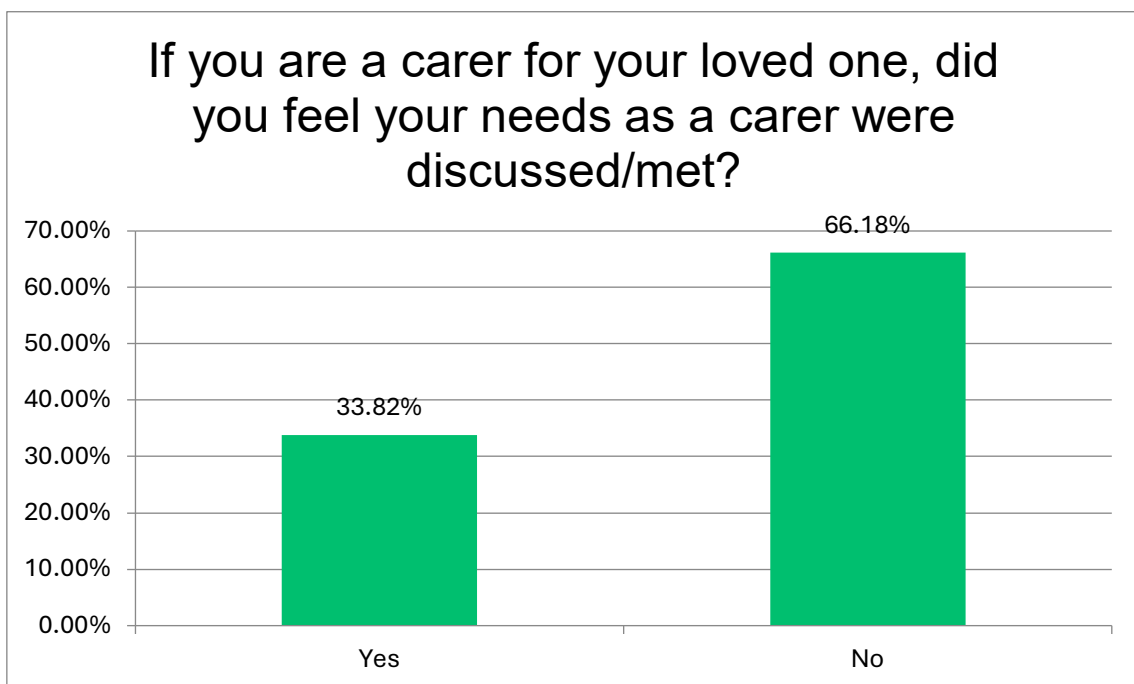
"No after care service at home no help with mobility."

"Discharged to home with only my autistic son for support and without adequate pain medication."

"We knew he wouldn't recover as Pendle couldn't help him at all."



Almost half of respondents stated that they were not provided with information, however this may not have been required for patients returning home.



Please expand on your answer to Q11 as a carer

Positive feedback from carers included: -

“I was involved in every single aspect of the discharge process.”

"Carers helped with assistance which I would have struggled with, and they couldn't do enough for us."

"I met with the management of the carers service and agreed everything in advance of my wife returning home."

Negative feedback included: -

"I am my uncle's carer nothing was discussed with me about his discharge or his needs until I spoke with the discharge social worker. This only happened as I know about it. If I didn't know I wouldn't have been included."

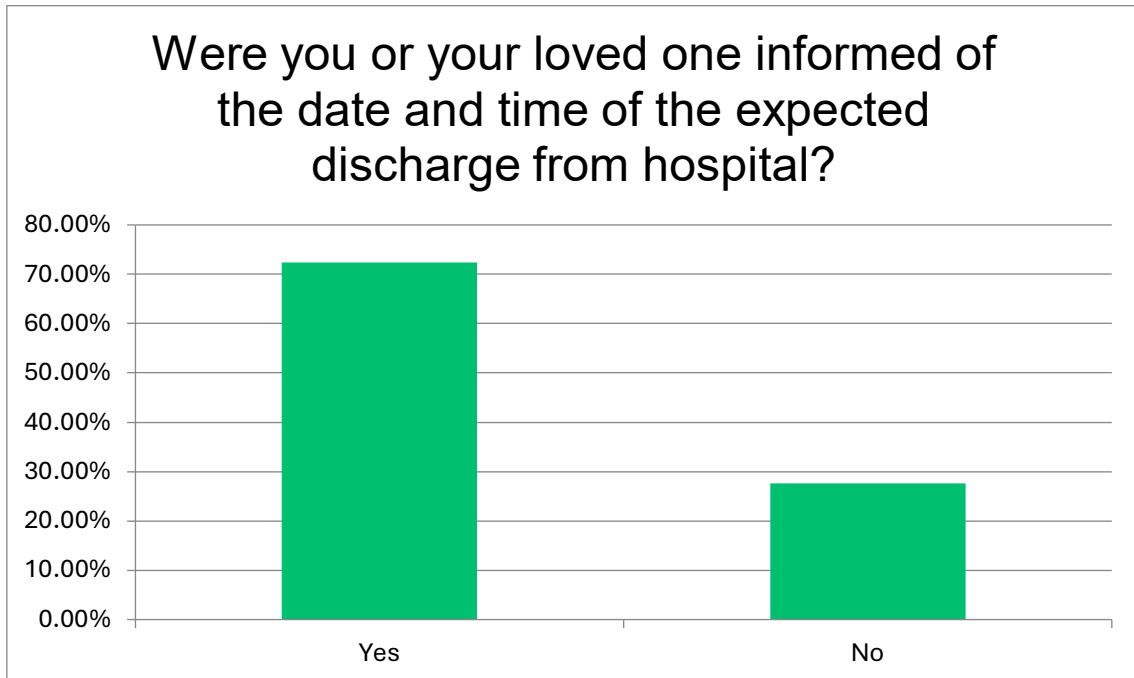
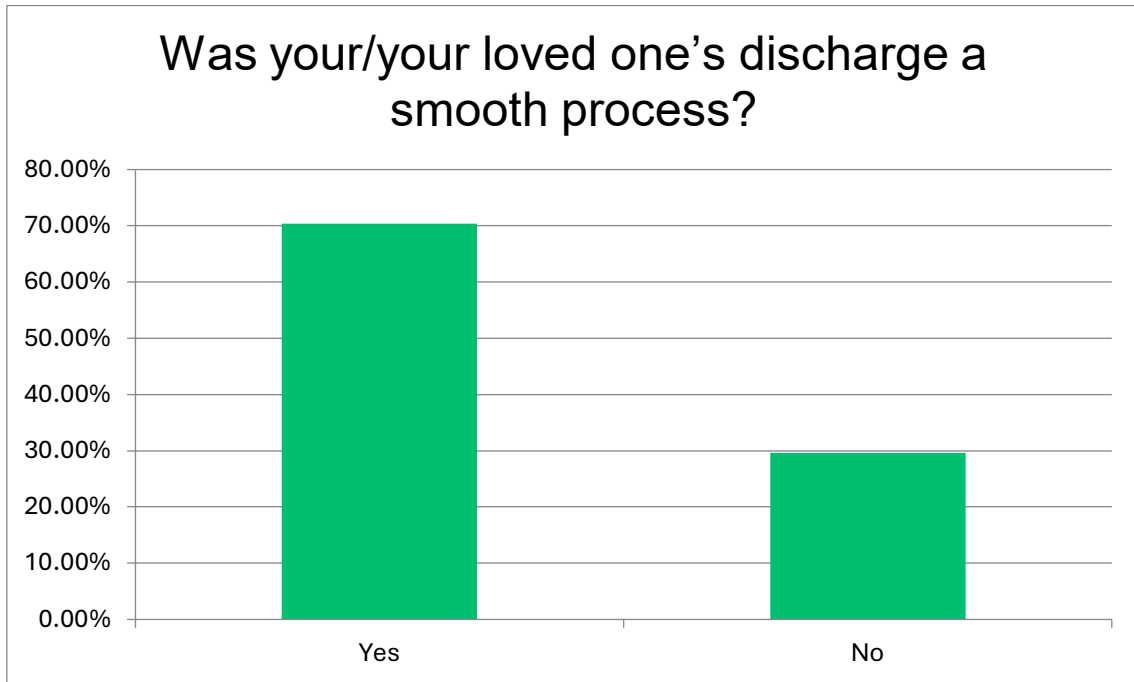
"Nobody really discussed my options to me. I was house bound for 6 month and the day before my husband died, I was told I could have had someone to sit with my husband if I needed to go out for an appointment."

"No... I wasn't asked or given signposting to all my needs. Only a few were shown via leaflet or number... I was never asked about my needs."

"When I need someone to come to our house, no one available. I asked the hospice or district nurses, GP for help, they said that is not their service."

"They are not interested they need the beds so it's like a production line no proper aftercare."

The Discharge Process



If no, please expand on any issues you faced e.g. transport, medication, suitable clothing, medical records, waiting time, communication.

“Did not know I was going to home until they were ready to discharge me.”

“Discharge was always hit and miss. I am partially disabled myself and had to get my husband home in the car most times. Sometimes I was told he could go home Friday then when the weekend staff came on his medication wasn't done so he couldn't come home till late Monday. Once he came home without some of the medication being incorrect. Communication shocking, all this stressed me out and my husband.”

“Time and distribution of medication a very big issue.”

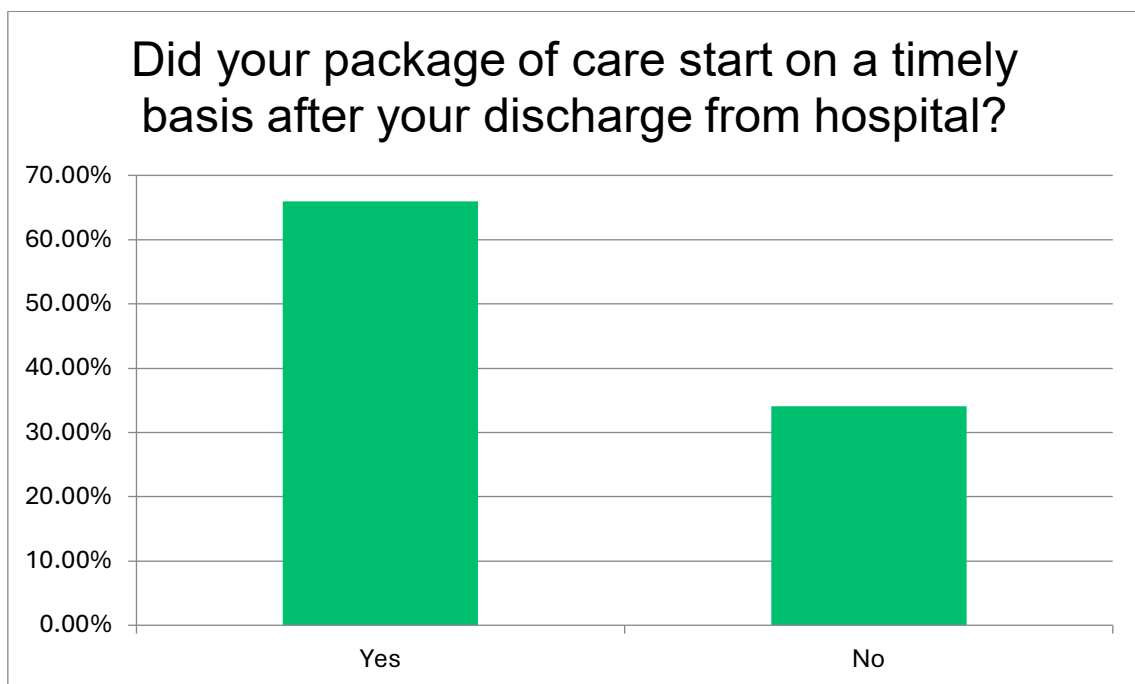
“I was not given a date or a time. I was left waiting.”

“Awaiting transport- no confirmation of time of discharge or whether it was certain to occur on the day it did.”

“I was visiting and told the patient was being discharged I could take them home now I was dropped on not prepared.”

“No as had difficulty arranging hospital bed transfer from hospital to home... wasn't told about the regulations of having my cared for one taken up steps into house or up the stairs to the specialised hospital bed.”

“No update. Sudden afternoon call he is coming home today.”



If no, please give details.

"TAD was not completed so after waiting for a phone call we had to find out who to contact for support."

"I had to find relevant services independently."

"I had to do all the running here."

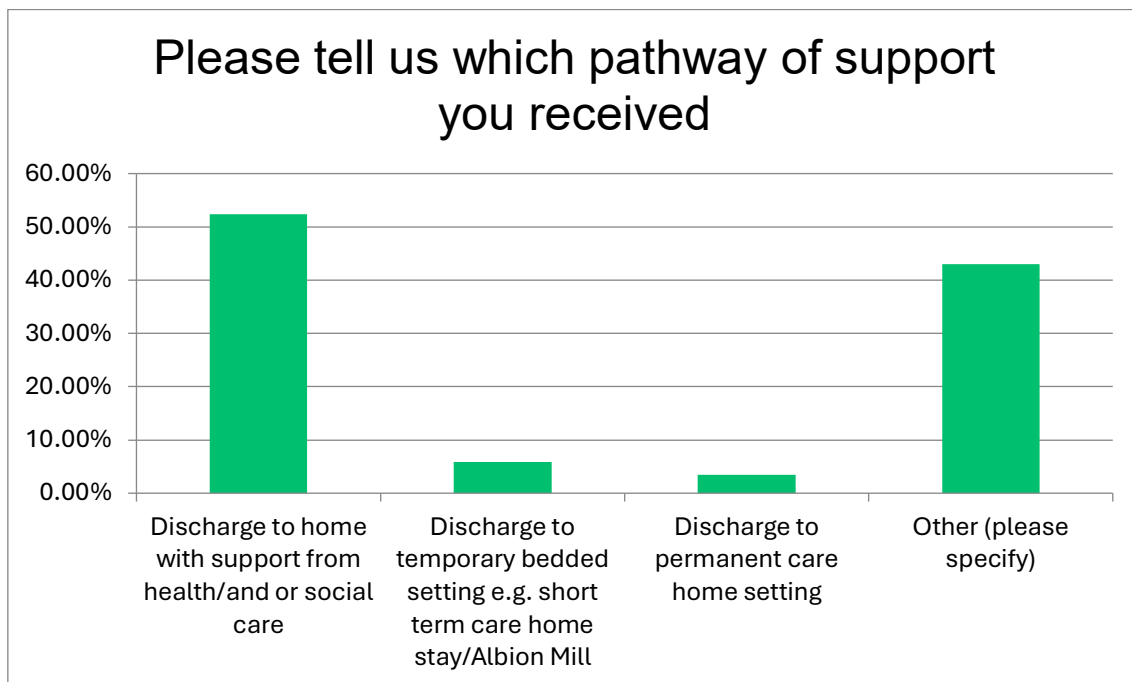
"There was no package of care."

"Especially disgusting when you consider I had major surgery and am a level 4-5 frailty."

"I organized private care."

"No immediate follow up or monitoring."

Experience of recovery setting



Responses to "Other" included: -

"Discharged to daughter's care at home as planned."

"Family care"

"With no support just my wife and slept on chair."

"Sent home with no support."

"We were discharged to home and wait for call received."

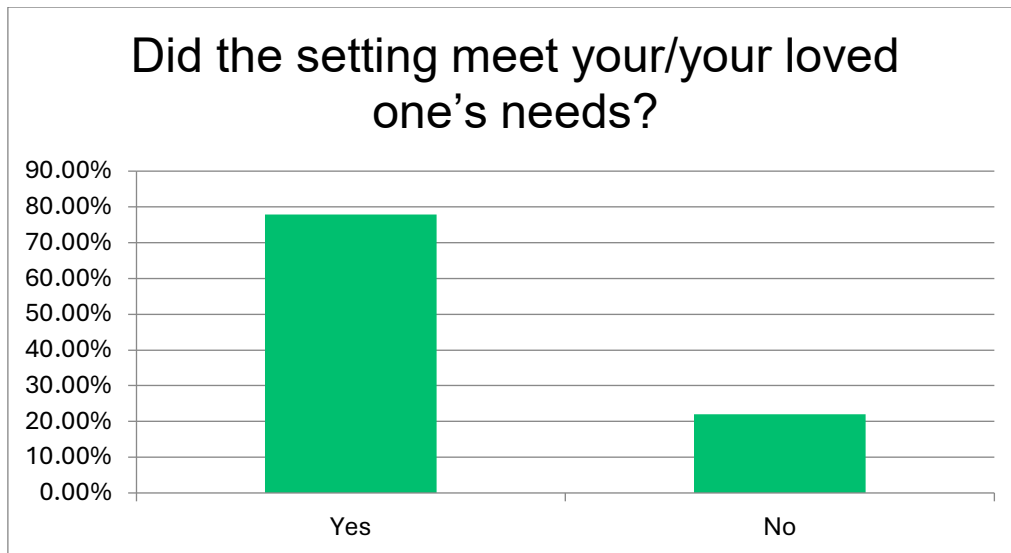
"I was handed over to physio."

"Home with Outpatients care."

"Discharged to a care home."

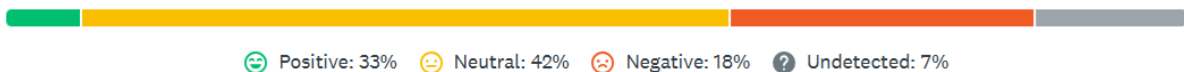
"Discharge home but with no help apart from a foot stool and raised toilet seat."

"Home to carer at home."



Please expand on your answer

How people feel:



Positive feedback included: -

"Great facilities helped to get mobile again."

"Yes I had everything I needed was provided with comfort great meals and unobtrusive supervision."

"With visiting physiotherapist, home was by far and away the best option for me."

"Thorncliffe is a good care home, he was looked after well."

"Yes, it was the cared for one's own home. So, familiarity ... as dementia was a concern."

"Homecare were outstanding."

Neutral responses included: -

"Came home."

"Home is where the heart is."

"We could have done with someone to talk to, for advice and help."

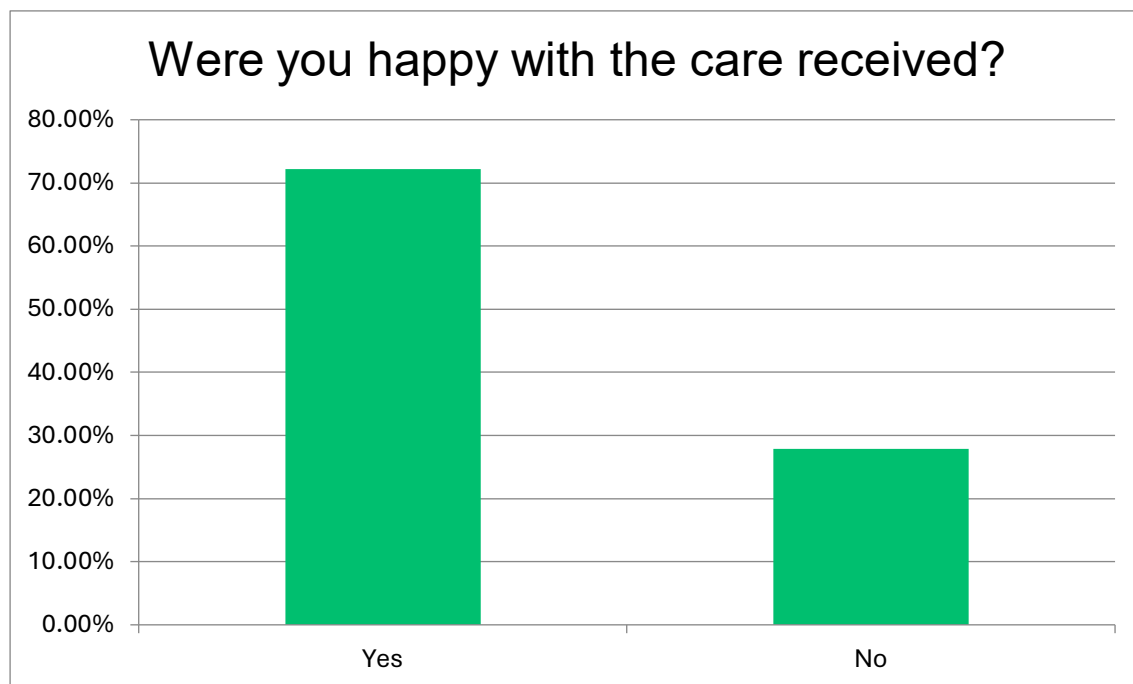
Negative feedback included: -

"Not suitable. It had 15 steps. I couldn't walk without a Zimmer frame, and I wanted to be independent so I could attend the activities I had attended previously."

"Carer comes for changing his incontinence pants. That's it. Nurse doesn't come as much as they did."

"Not all the aids at daughters house to support the patient fully."

"Everyone too busy and run off their feet."



Please expand on your answer

Positive feedback included: -

"I was happy with the care in hospital."

"Nurses were kind and caring."

"Had support for exercises and medication."

"Caring fantastic joint health and social care team."

"All agencies involved were helpful and obliging."

"People were very helpful."

"I had support from IHSS and my family."

"I was very pleased with the treatment I received both in hospital and at home."

"District Nurse was superb with all aspects of care."

"The carers that visited us on a daily basis were 100% dedicated to the care they provided. They were smartly turned out and extremely helpful in every way, they

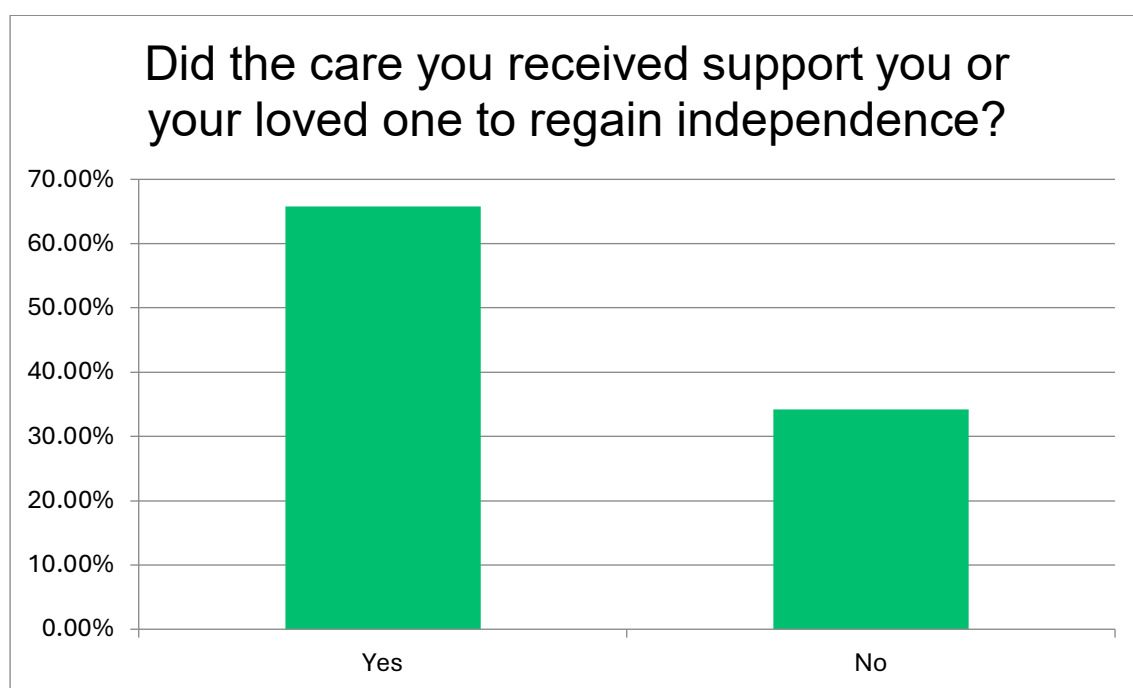
were passionate about they did and carried it out in a professional and caring manner.”

“Couldn't have been looked after any better.”

Negative feedback included: -

“I've answered yes, the carers did their best, but I feel my husband should have had more specialised care as the last 2 weeks he was in shocking pain and couldn't bear to be touched. It was heart breaking.”

“The staff didn't care. The support wasn't there.”



Please expand on your answer

Positive feedback included: -

“District nurses very professional.”

“Community stroke team were extremely helpful and I don't think we could have managed without them.”

“Home assessed and devices provided continued support from community nurse for wound spot on.”

“Physio are working with me to gain full mobility of my shoulder.”

“Was helped with care until I felt comfortable to do things myself.”

“Physiotherapy at home greatly helped a speedy return to mobility.”

“The very best attention was given by the District Nurses who attended me.”

"I was encouraged and well informed."

"I was given some further adaptations for our home."

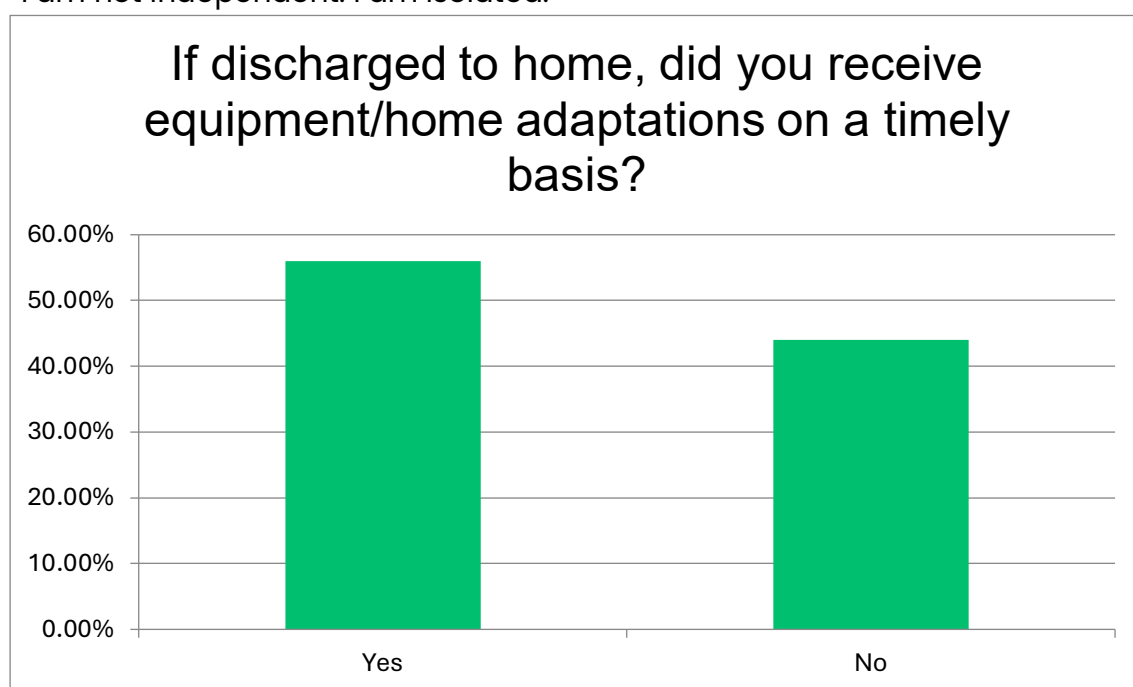
Negative feedback included: -

"Not fully as this was my frustration. It's taken over 2.5 yrs for me to have 90% independency. I still had to do medications, feeding... (which was actually part of the package on discharge. As far as I was aware). So that's left me very upset, frustrated and loss of my life and routine."

"That was good service, but I don't know why it took so much time."

"No home support."

"I am not independent. I am isolated."



If no, what delay did you experience?

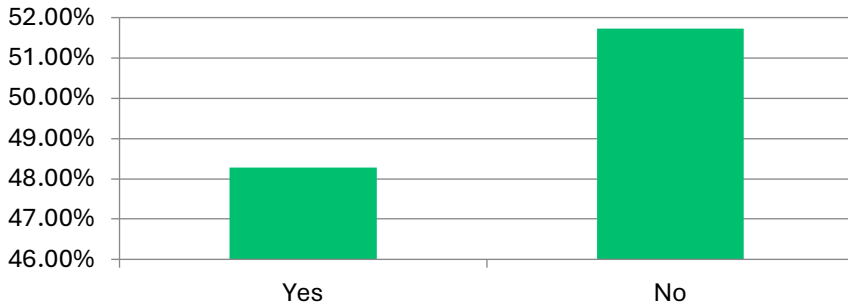
"I was discharged without a package without access to the top floor in a safe manner. I was left to fend for myself and I was isolated."

"I would say 90% of equipment arrived in a timely manner... so specialised equipment was not in stock."

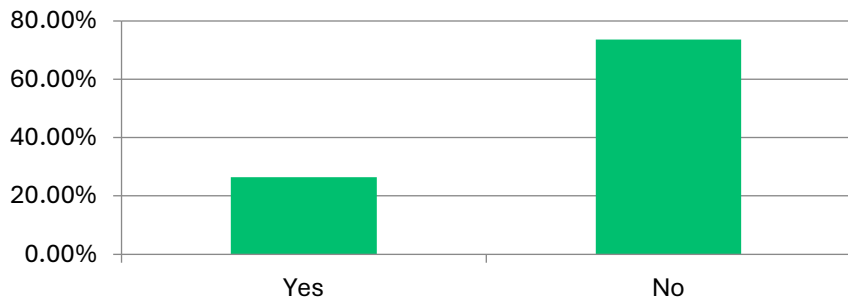
"Waiting for final adaptation but confirmed it will take place later today."

"Left alone with a walking aid frame."

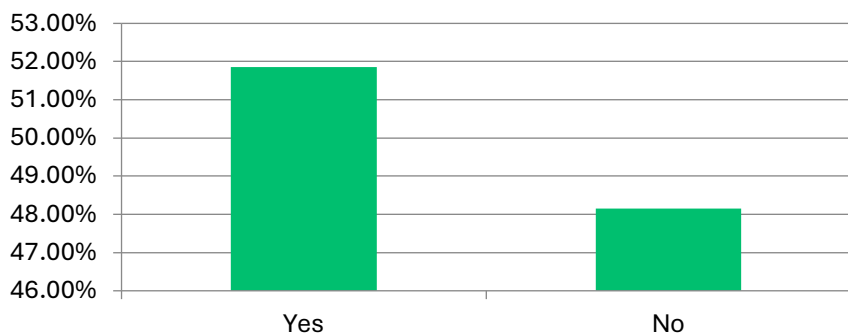
If discharged to a bedded setting/care home, was it easy for family or friends to visit you/your loved one?



Were you involved in discussions around financial matters associated with your/your loved one's care?



Were you given appropriate information about next steps after your/your loved one's package of care ended?



Please expand on your answer

Positive feedback included: -

"District nurses showed my partner how to empty my catheter."

"I was passed over to a balance and strength class at Darwen leisure centre which I still attend."

"Ongoing training to help with colostomy care given."

"Contacts information provided for further information/assistance if needed."

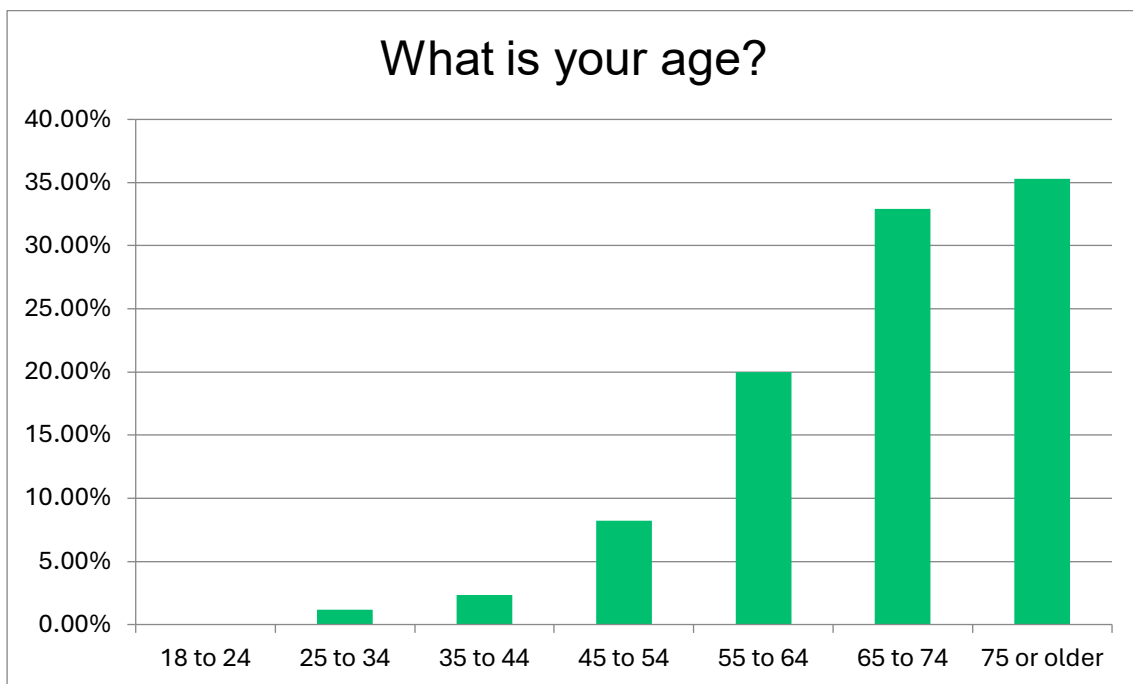
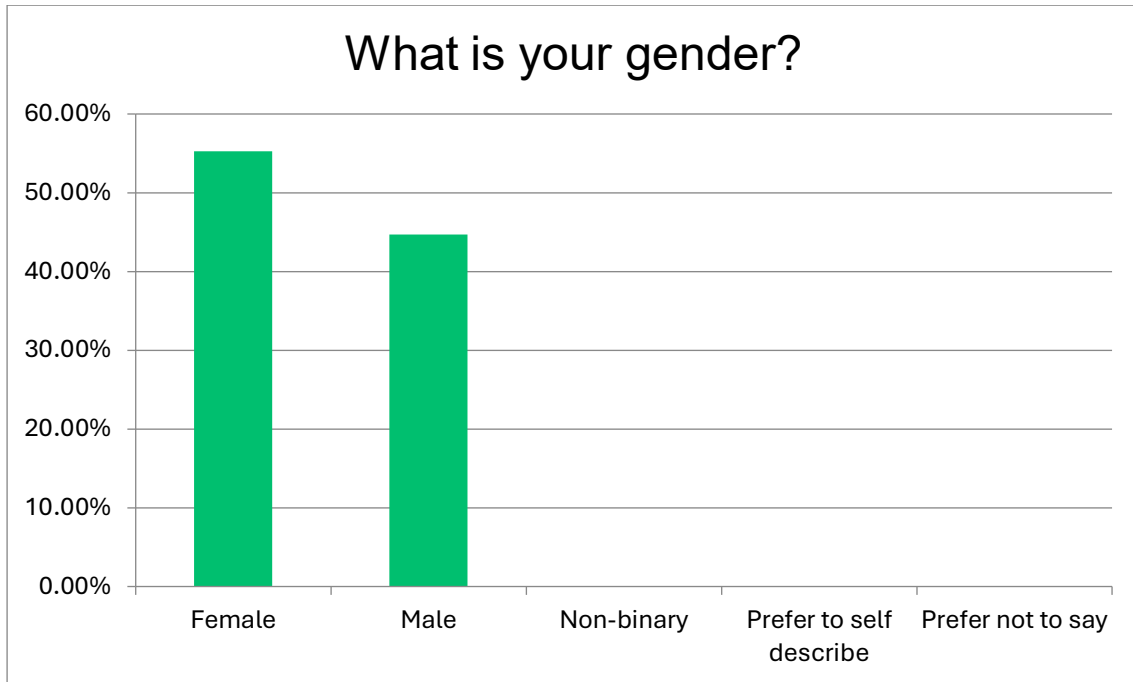
"Explained to social worker that I was confident to look after myself with my husband's help. It was explained to us that there would be a financial cost when the care package was over."

"Informed about financial and health support."

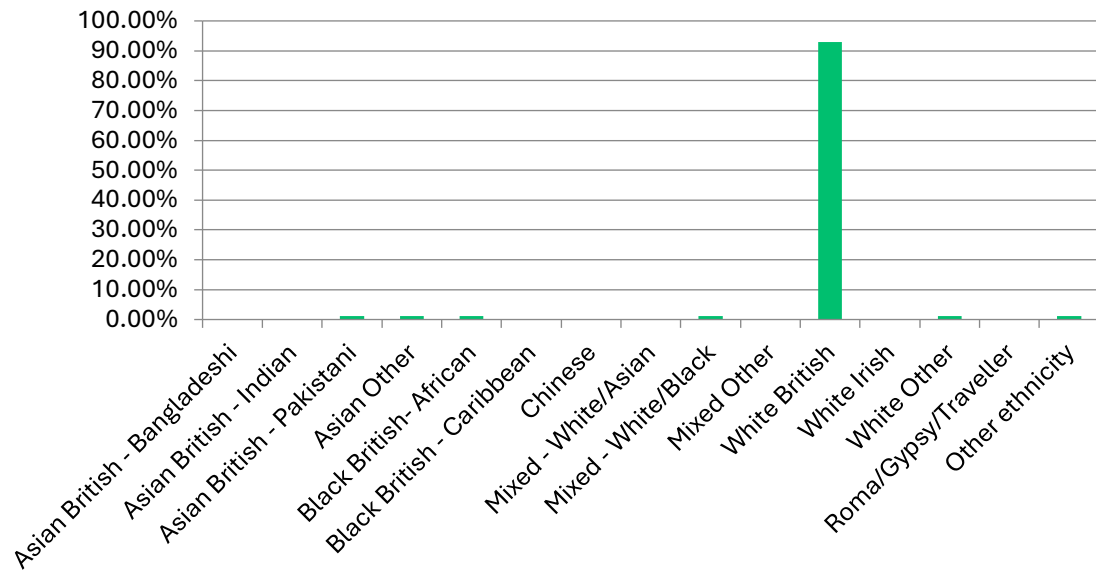
One negative feedback received from a respondent was that.

"My wife has been my carer for over 20 years and continues to be so, although totally unpaid, which I feel is a disgrace."

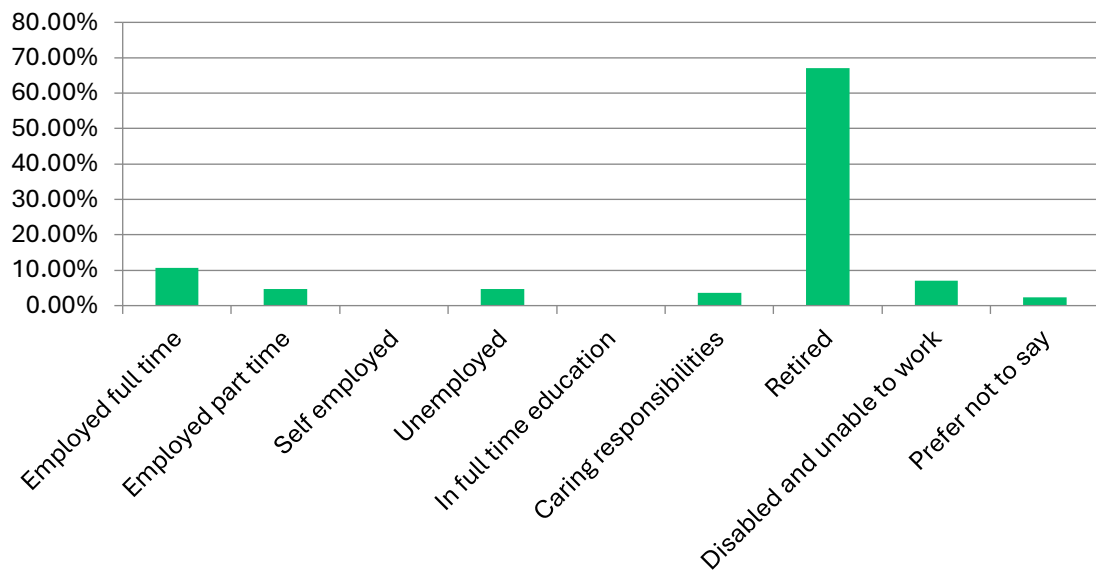
Demographics



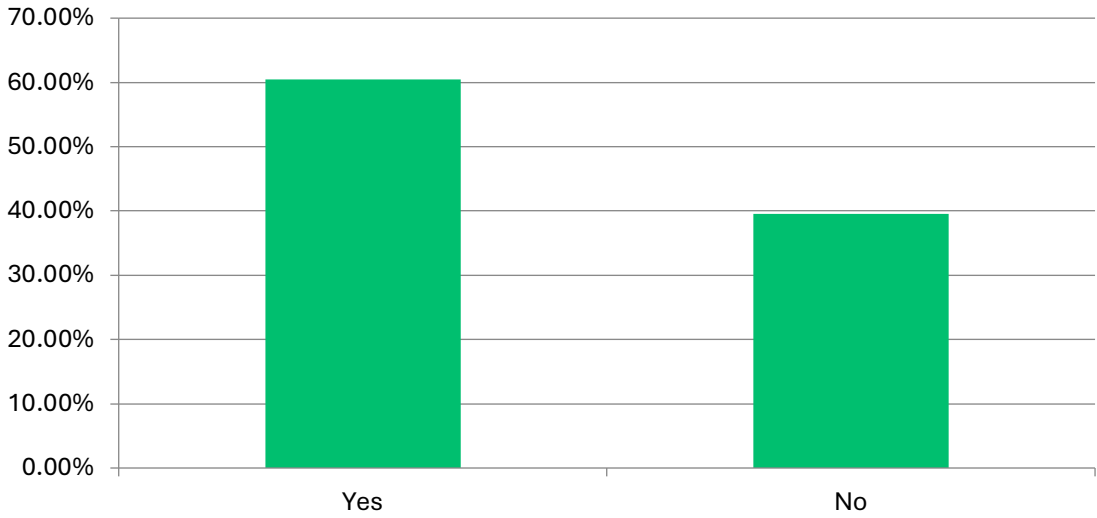
What is your ethnicity?



What is your employment status?



Do you consider yourself to have a disability?



If yes tick all that apply

