healthwatch Sunderland

Guiding You Home

Feedback from relatives/friends on hospital discharge arrangements

February 2026

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Background

Health and social care leaders in Sunderland want to improve the outcomes of people discharged from hospital by promoting 'home first' as the priority.

A programme designed to speed up hospital discharge by supporting patients to return home has been launched by NHS and local authority leaders.

Called 'Guiding You Home', it aims to support as many patients as possible who have an urgent health or care need to receive that care as close to home as possible, as part of neighbourhood working.

The initiative is designed to ensure that people are given the right care in the right setting from the point of preparing for hospital discharge, through home-based services and 'returning to independence' beds.

'Home first' will be promoted as the priority, with the questions asked 'why not home?' and 'why not today?'.

The partnership behind 'Guiding You Home' includes South Tyneside and Sunderland NHS Foundation Trust, South Tyneside Council, Sunderland City Council and North East and North Cumbria Integrated Care Board.

Ward teams, including doctors, nurses, therapists, discharge nurses and social workers, will liaise with patients and carers to discuss discharge arrangements early in their hospital stay.

This multi-disciplinary discussion will support the patient's wishes and challenge assumptions that a care facility is best, coordinating a health and care response to support the patient home where possible.

Methodology

As part of the research and consultation process, Healthwatch Sunderland developed a short survey in partnership with South Tyneside and Sunderland NHS Foundation Trust and Healthwatch South Tyneside.

Relatives and friends of hospital patients were asked what care and support they would like to see in place to enable them to return to their own home rather than going into a care home. The survey also asked what type of support and reassurance carers would need to help them support their relative/friend going home after a period in hospital.

This survey ran for four weeks between January and February 2026, with an online version being shared widely using Healthwatch Sunderland networks and social media platforms.

The survey link was advertised by South Tyneside and Sunderland Hospital Discharge Support and via the Integrated Care Board's People's Hub Newsletter.

We provided print versions of the survey to use during face-to-face outreach at Sunderland Hospital and during our ongoing schedule of outreach and engagement events across Sunderland.

Findings

There were four questions asked, with 31 respondents taking part in the survey.

Q1. Following a stay in hospital for your relative/friend, what care and support would you like to see in place to enable them to return to their own home rather than going into a care home.

The kind of care and support relatives and friends asked for to enable a return home included:

- **Communication and Information** - clear communication from doctors and staff to patients, families, and relatives. Improved updates about the patient's health should be provided, along with more information before discharge to help families prepare for the transition.
- **Support and care packages** - Support and care packages can be put in place to help patients feel comfortable after discharge. For instance, booking physiotherapy sessions in advance and prescriptions ready promptly will help make the discharge process smoother. Also, having professional carers who are knowledgeable of the patient's health condition would be beneficial.
- **Equipment and home preparation** - Additionally, homes should be checked for safety and all mobility aids installed or available where possible to avoid long waits after discharge and to ensure that patients receive proper care.
- **Follow up support and after care** - The survey indicates that patients would like a phone helpline for easy access to aftercare and other vital information . Where appropriate home visits are available to monitor the patient's recovery progress.

Overall, respondents want a well-coordinated, informed, safe and person-centred discharge process.

"A smoother discharge. Prescriptions to be ready shortly after discharge, not waiting hours for them, blocking beds. Communication with family members, especially with independent elderly, to ensure support is organised. A lot of old people (experienced with my parents) will say anything to get out of the hospital into their own home."

"More support is put in place when discharging the patient with aftercare information."

"Mobility aids, checking the home is safe. Telephone contact or home visits. Home physiotherapy to help them get stronger."

Findings

Q2. Do you think a care home would provide better care than what could be offered to your relative/friend in their own home?

Responses to this question were mixed: 52% said no, 23% said yes, and 25% were unsure.

Respondents who replied “no” were asked to explain their response. Most indicated that home was more familiar and typically the first choice for people. Several respondents noted that while care at home could be a good option, it should only be considered if proper care and support were identified and in place. Many also acknowledge that, in general, people tend to recover more quickly at home.

Among those who replied "yes," several stated that home care might not be suitable for all patients, particularly those living with dementia, who often require extensive support. They emphasised that such patients would benefit from being in a care home because of the need for constant supervision and individualised personal care offered, although this can depend on the severity of the case.

Finally, those who were unsure expressed that their opinion depended on the individual’s needs at the time of discharge.

People want to keep relatives at home where possible — but only if discharge is safe, supported, and well-coordinated. Many feel current systems fall short.

“Depends on the care needs of patients. If patients want to return home and their needs can be met, home is usually the best outcome. If safety cannot be maintained, then 24hr support will be required to ensure the patient’s safety and wellbeing.”

“For some elderly people, it is good to have round-the-clock support available, but for others, they prefer the familiarity of their own home, with required support. It would be good to have options suitable for individuals' needs.”

“My husband has dementia and is now in a home, where they look after him wonderfully.”

“You know your relative and understand their needs. If you get the right support, your relative will be more comfortable at home. Everyone prefers their own bed and home comforts.”

Findings

Q3. What type of support and reassurance would you need for yourself to help you support your relative /friend going home after a period in hospital (e.g. time from work, telephone helpline, key contact information for support available, etc.)

Responses to this question could be summarised as:

- **Access to information and support** - Respondents would like to see the establishment of a single point of contact helpline that offers 24/7 support. This helpline would help patients reach the right team effectively and ensure timely responses. Additionally, providing an information booklet with key agency contacts would support patients and families in navigating ongoing care at home.
- **Practical care and support** - Respondents would be reassured that all the necessary practical care and support are in place before discharge, the patient is fit enough to return home, and all parties are involved in care planning, and follow-up check-ins are scheduled.
- **Support from employers** – Carers would like to see additional support and understanding from their employers to help them balance their caring responsibilities while maintaining their jobs.

"That discharge is not mentioned nor agreed until the care package is guaranteed to be in place, and that patient's needs are discussed with family by their consultant/doctor before agreeing to discharge."

"Again, clear communication and a book or leaflet with the relevant information and contact numbers."

"That the patient is physically capable, safe, and able to return home, time off work for the first week or two to understand what support is required at home, with potential flexible working arrangements to support. Emergency alarm support for patients in case a fall occurs, and they cannot call for immediate support or help. Care worker assessment of the home, meeting any needs or equipment requirements."

"Telephone helpline and maybe a call from a GP after a couple of days, or a visit by recovery at home to see how things are."

"A few weeks' paid leave would be a big help to most people trying to bring an elderly relative back to their home, and this allows them to get support sorted for them without the worry of having to go to work."

Findings

Q4. Is there anything else you would like to tell us regarding care at home or in a care home?

Many respondents shared their experiences of being discharged home or to care homes. They emphasised the importance of effective communication and coordination of services, as well as helping individuals understand the benefits of a home-first approach.

When these aspects are not addressed properly, families often face significant challenges. Many feel overwhelmed and burdened as they navigate these issues, trying to balance caring for their loved ones with their work responsibilities.

"Make family more aware of the benefits for an older person staying at home as long as possible with the care package and support needed."

"Care home was Arches Park in Farringdon. They looked after both my Mam and me. Very caring, very straightforward. When my Mam's condition deteriorated the care home were happy for her to stay there for end-of-life care but they were overruled by paramedics and admitted to hospital. There was a long stay in A&E and then on a ward where no one knew her. I wish she could have stayed in her own bedroom with people she knew."

"Better preparation and notification from the hospital of long-term plan. When visiting a relative in hospital, staff were dealing with day-to-day issues; there was never any communication based on progress or a long-term plan. We had to really try hard to find out who could give us answers, and it was painful at times."

"Your methods of discharge need to be reviewed if the patient is elderly and has cancer, like Mum. Palliative care is in place now, but her complete lack of an efficient and adequate home care package initially was very stressful and left me chasing the people who should have been on hand immediately. Must do better. "

"Having lived through the caring role for a number of years, the hardest part has been the battle to get the right level of care, which is time-consuming and energy-sapping."

What needs improving

Based on the feedback we received from families and carers, we identified key areas that need improvement in the discharge process to ensure a smooth transition for patients and their families or carers from hospital:

- Timely and effective communication – there should be ongoing discussions among healthcare professionals that involves the patient and family regarding both immediate and long-term plans for the patient's care.
- Clear discharge plans - once discharge is agreed upon, the discharge plan must be clearly communicated to all relevant agencies. This ensures that appropriate support and care packages, including home safety checks, risk assessments, prescriptions, and mobility aids, are established before the patient leaves the hospital.
- Home care – providers should be assigned to patients prior to discharge and informed of the discharge plan to ensure that care is delivered effectively and meets the patient's needs.
- Information packs for families - all patients and their families or carers should receive an information pack containing essential contact details and guidance on whom to contact if they have questions or encounter difficulties at home. This will help ease the burden that many experience during the transition.
- Dedicated helpline – A 24/7 dedicated helpline should be established to assist families and patients with a single point of contact for support in navigating any ongoing assistance they may need.
- Support information for family members/carers - If family members or unpaid carers recognise that they need assistance managing their caring responsibilities after discharge, they should be provided with information about support organisations, such as the Carers' Centre. Additionally, information about their employment rights, including entitlements to carers' leave and flexible working arrangements, should also be shared.

Provider response

"Thank you, Anna and the Healthwatch Team, for completing an excellent piece of work to help inform the next steps of the Guiding You Home Programme.

The information gained is very valuable to the programme, and from this I can see that we are in agreement with your recommendations and will endeavour to ensure all of our documentation for discharge covers the points raised, as well as ensure our discharge planning begins as early in the patient's stay as possible.

Communication around discharge arrangements was a clear message from the feedback. I look forward to working with you on the implementation of the changes needed and going forward as part of Guiding You Home."

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