

Factsheet 37

Hospital discharge

August 2018

About this factsheet

This factsheet explains what you should expect from staff planning for your discharge following NHS treatment in England. Your hospital stay should be no longer than medically necessary and you should receive ongoing care and support in the most appropriate place.

You may like to read other Age UK factsheets about care and support available from your local authority social services department, funding care at home and in a care home, and NHS continuing healthcare.

The information in this factsheet is applicable in England. If you are in Scotland, Wales or Northern Ireland, please contact Age Scotland, Age Cymru or Age NI for their version of this factsheet. Contact details can be found at the back of this factsheet.

Contact details for any organisation mentioned in this factsheet can be found in the *Useful organisations* section.

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1 Introduction

A hospital stay can be a difficult time for you and those close to you but is likely to be less stressful if you know what to expect.

If your admission is *planned*, your hospital stay and abilities on leaving are more predictable. When agreeing to treatment, ask the doctor what you can expect when ready to go home, so you can plan ahead.

An *emergency admission* brings more uncertainty but there are steps staff should follow so your hospital stay is no longer than necessary, and the right care and support is in place when you are medically ready to leave.

This factsheet covers issues around a hospital stay but the focus is on how staff should manage your discharge following NHS funded treatment in England. Planned NHS treatment is generally provided in an NHS hospital but may be provided in a private hospital.

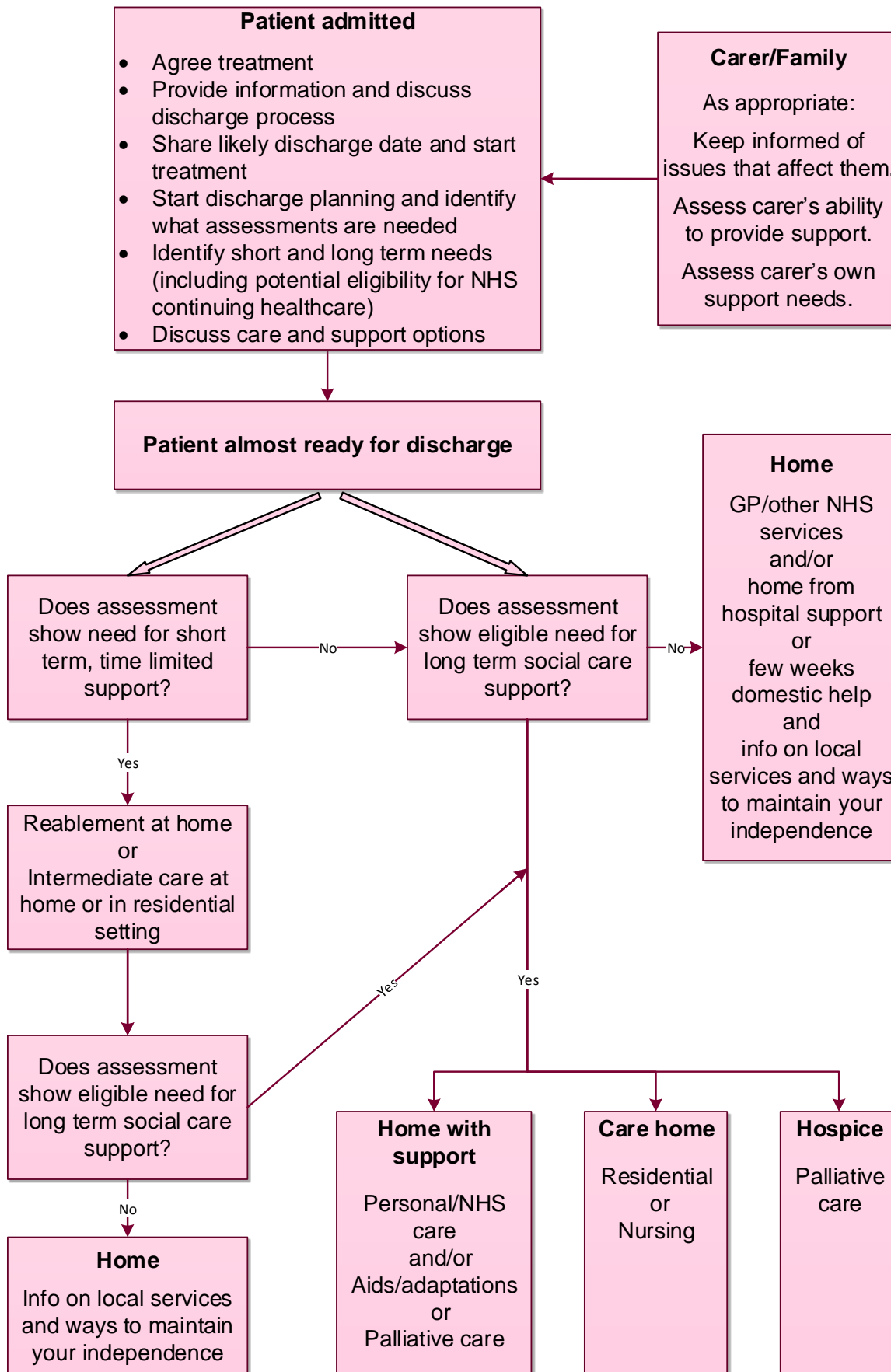
2 Hospital discharge – key steps

Staff should:

- 1 Provide information about the discharge process in a format you can understand and engage with.
- 2 Start discharge planning as soon as possible after they make a diagnosis and agree a treatment plan with you. They should involve you (and your carer or family as appropriate) at all stages.
- 3 Share an expected date of discharge (EDD) with you as soon as they know it, review it regularly and promptly inform you of any change.
- 4 Appoint a discharge co-ordinator to manage assessment of your short and/or long term needs, if your discharge is likely to be complex.
- 5 Consider if you might be eligible for NHS continuing healthcare.
- 6 If a care assessment finds you eligible for local authority support, consider your views on how best to support you, discuss your options and agree and draw up a care and support plan with you.
- 7 Arrange assessment of your ability to pay towards the cost of ongoing social care, if you are eligible for local authority care and support.
- 8 If not eligible for local authority support, provide information and advice so you understand your needs and can arrange your own care.
- 9 If your partner or carer will provide care and support on discharge, identify their needs for support and discuss how these might be met.
- 10 Ensure your discharge plan - information about your treatment, on-going health needs and medication - goes promptly to your GP and care home.
- 11 Deliver and monitor your care plan.

The flow chart on the following page summarises this journey.

Hospital discharge pathway



3 Going into hospital

3.1 Planned admissions

A GP hospital referral leads to an outpatient consultant appointment to explore or confirm your diagnosis and discuss treatment options.

The referral should explain any communication needs you have. This may mean the hospital should send appointment letters and information in large print, easy read, Braille or audio. It may mean the hospital must arrange a British Sign Language interpreter, lip reader, deaf blind interpreter or advocate so you can take an active part in discussions at your appointment. If the hospital knows English is not your first or preferred language, it can invite a registered interpreter to assist you.

Questions to ask at an outpatient appointment

- Do I need further tests? If so, what are they for? Where and when can I have them? How long before I get the results and how will I get them?
- What treatment would you recommend and why?
- What are the benefits, side effects, risks and success rates of each treatment you are proposing? How frequently is the treatment required?
- What improvements can I expect in my condition or day-to-day life with each treatment option? When might I start to notice improvements and can I expect a full recovery?
- What would be the consequences of doing nothing or waiting a while?
- Will tests or treatment require me to be an inpatient or day patient?
- If I'm an inpatient, what is the likely length of my stay?
- Is there anything I can do to support my recovery before my treatment, while in hospital and once home?
- How long before I know if the treatment has worked or is working? When will I be able to start going about life as usual? Will I need help at home? If so, what type of help and for how long?
- Do you have written information about my health condition, treatment or national or local support groups? What websites would you recommend?

Under the *Equality Act 2010*, it is not lawful for doctors, without good and sufficient reason, to offer or provide inferior treatment or refuse to provide treatment at all solely because of your age. Age can play a part but staff should take into account your '*biological*' age (how well your vital organs and systems are working), not simply your '*chronological*' age (your age in years).

You should tell staff about your home environment and any help you receive from social services. The more they know, the easier it is to ensure you have the right support on leaving hospital.

3.2 Emergency admissions

Calling an ambulance or being taken to the Emergency Department (ED) does not always result in admission to hospital.

Following an appropriate assessment and initial treatment by ambulance paramedics or ED staff:

- you may be discharged and need no further treatment, or
- you may be able to stay at, or return, home. Many ambulance services and EDs can contact a '*crisis response team*' who can arrange short term (48 – 72 hour) health and/or social care support at short notice. This can prevent unnecessary trips to ED and hospital admissions, or
- you may be moved to a special ward for tests or monitoring to help decide whether to admit you. This may be called a clinical decisions unit or medical assessment unit.

Your Summary Care Record

You have a Summary Care Record (SCR) if you agreed the NHS could create one from your GP record. It contains up-to-date information about your medicines, those you react badly to and any allergies. With your GP, you can agree to adding other information about your health and preferences that could help doctors in an emergency.

If you are unable to communicate with staff, accessing your SCR helps a doctor understand your health history and make a diagnosis. Only a doctor or health professional with special permission and a unique PIN number can see a SCR in emergency situations. Where possible, they must ask your permission to view it. If you cannot give permission, for example because you are unconscious or have advanced dementia, staff must decide if it is in your '*best interests*' to look at your SCR.

Admission assessment

Many older people live with one or more health conditions and whereas staff are likely to focus on the main reason for your admission, it is important they enquire about your health more broadly. It may have a bearing on this admission and identifying issues now, may prevent future problems.

It could be that walking and completing everyday tasks have become more difficult and tiring. You may have had one or more falls recently, even though you were not injured. You may have developed bladder problems or noticed unintended weight loss or problems with your memory or thinking skills.

If this is the case, the doctor may decide to involve a specialist older persons' team in making a diagnosis, when discussing treatment options with you and in your assessment prior to discharge.

4 Your hospital stay

4.1 Your rights in hospital

Your rights and responsibilities as a patient and of NHS staff who care for you are set out in the NHS Constitution. As a patient, you have various rights, including to:

- receive services and not be discriminated against because of age, gender, race, religion or belief, sexual orientation or disability
- be treated with dignity and respect in accordance with your human rights
- be treated by appropriately qualified and experienced staff in a clean, safe and secure environment
- be involved in planning and making decisions about your health and care, including end of life care and be given information and support to allow you to do this, where appropriate involving your family and carers
- be given the chance to manage your own care and treatment
- be given information about the test and treatment options available to you, what they involve and their risks and benefits
- accept or refuse treatment offered
- receive drugs and treatments approved by NICE (National Institute for Health and Care Excellence) that your doctor says are right for you
- expect confidential information to be kept safe and secure
- receive suitable and nutritious food and hydration to sustain good health and wellbeing
- have any complaint you make about NHS services acknowledged within three working days and have it properly investigated.

Eating and drinking

Eating and drinking enough is an important part of your recovery. Staff should place food and drink where you can reach it and if you need it, offer help to drink throughout the day and at mealtimes. Speak to the nurse in charge of the ward if you:

- need help choosing from or filling in the menu
- need a special diet because of a health condition
- find menu choices unsuitable because of allergies, cultural, religious or personal preferences
- need help cutting your food or opening cartons
- have trouble chewing your food.

Staff may weigh you on arrival and at regular intervals, so they can address concerns about your weight. They should ensure staff are aware of and address dietary/weight issues when planning your discharge.

4.2 Making decisions about treatment and care

Staff must seek your permission to carry out tests, treatment or an assessment of your care needs and to share information about you with other professionals.

If you seem unable to make these decisions, staff should ask family members if you usually need help to make decisions, if you have made a health and care decisions Lasting Power of Attorney (LPA) or whether a Welfare Deputy has been appointed by the Court of Protection to act on your behalf. They should also ask if you have made an advance decision to refuse treatment.

If you have not appointed anyone to act on your behalf and staff confirm you lack capacity to give consent or make a decision when it needs to be made, an appropriate member of staff must make a decision in your '*best interests*'. To inform their decision, staff should consult people who appear to have a genuine interest in your welfare. This usually includes family and friends as they can provide valuable information about you and your circumstances.

If NHS or local authority staff must make a '*best interests*' decision on your behalf involving serious medical treatment, a permanent change of residence, or temporary one lasting more than eight weeks and you do not have family or friends other than paid staff to consult about the decision, staff should appoint an Independent Mental Capacity Advocate (IMCA). The IMCA's role is to work with and support you and make sure those working in your best interests know your wishes and feelings.

The *Mental Capacity Act 2005* governs the rules to be followed if you lack capacity to make decisions for yourself and applies to anyone acting in your '*best interests*'. Doctors, nurses, social workers, other health professionals and support staff have a duty to ensure they are trained in its implementation and are expected to understand it as it relates to their own responsibilities.

The Act aims to protect people who cannot make certain decisions for themselves and empower them to make these decisions where possible. You can arrange for someone you trust to be your attorney and make decisions on your behalf if, at some time in the future, you can no longer make them for yourself.

More information about attorneys is in factsheet 22, *Arranging for someone to make decisions on your behalf*. For information about advance decisions to refuse treatment, see factsheet 72, *Advance decisions, advance statements and living wills*.

4.3 Involving your family or carer

On admission, most hospitals ask you who you would like them to contact in an emergency.

If you want your family or carer to be informed or involved in discussions about your treatment or discharge arrangements, tell hospital staff and ask them to record this in your notes.

Staff should give your informal carer information that enables them to safely carry out tasks they agree to undertake on your behalf. If family members are responsible for making arrangements to meet your ongoing care needs, staff should provide information so they understand the type of care to look for.

4.4 Supporting a patient living with dementia

Time spent in an A&E department or hospital ward can be frightening and confusing for people with memory problems or dementia. If you have dementia, it is helpful for your family to share information with staff about how dementia affects you. This helps them provide appropriate care and helps you get maximum benefit from a hospital stay.

This might include letting staff know what name you like to be called, about sight or hearing difficulties, usual routines, food preferences, help needed with eating and drinking, sleeping preferences, pain you may experience, what might agitate you and what calms and reassures you.

You or a family carer can record this information in a leaflet '*This is me*' available from the Alzheimer's Society.

The hospital may have its own initiative for staff or may support national schemes such as:

- **the Butterfly Scheme.** A family carer whose mother had dementia created this scheme that has been adopted by many hospitals. It aims to improve the care, safety and wellbeing of people with dementia while in hospital. For more information see www.butterflyscheme.org.uk/
- **John's Campaign.** A campaign to encourage hospitals to recognise the expertise of family members caring for someone with dementia and how welcoming them into the hospital and working with them, throughout a hospital stay and when planning discharge, benefits the patient and hospital staff. For more information, see <http://johnscampaign.org.uk/>

4.5 Benefits while in hospital

Your State Pension is paid as usual while you are in hospital.

If you receive Attendance Allowance (AA), Disability Living Allowance (DLA) or Personal Independence Payment (PIP), notify the Disability Benefits Helpline when you go into and come home from hospital. Payment is suspended once you have been in hospital more than 28 days, including the day of admission.

If you receive Pension Credit (PC) Guarantee Credit, losing these benefits can affect the amount of PC you receive. Payment of suspended benefits should resume when you are discharged, unless you start receiving local authority financial support towards permanent care in a care home.

If you receive Carers Allowance (CA) and go into hospital, it stops after 12 weeks. Tell the Carers Allowance Unit when you go in and when you come home from hospital. If someone receives CA for looking after you and you go into hospital, their CA stops when your AA, DLA or PIP is suspended.

Contact your local Age UK if you have queries about benefits while in hospital.

4.6 If your treatment is not funded by the NHS

If planned treatment in a private hospital is paid for by you or through an insurance plan, ask the consultant about the hospital's discharge procedure. Find out if personal care or other daily tasks might be a problem for you, ask whether you would benefit from aids to help with mobility or ensure your safety and what post-discharge support the hospital provides.

You have a right to an assessment by your home local authority once it is aware you may need community care services. Social services staff are not based in private hospitals, so having an assessment can present practical problems.

Contact your local authority social services department as soon as your admission date is confirmed. Explain the kind of support the consultant says you might need and for how long. This could indicate if your needs are likely to meet national eligibility criteria for care and support. You may be asked to contact them again once admitted.

Social services have a duty to meet your needs if they meet eligibility criteria. You may have to pay towards the cost of services arranged, see sections 5.3 and 7. If you are likely to need help but are not eligible for local authority support, you can contact a private care agency.

Your local Age UK may offer practical support to people newly discharged from hospital or have details of other voluntary organisations that could help. They may charge for this type of support.

5 Preparing for discharge

Staff should provide you (and your partner or family if appropriate) with information about their discharge process as soon as possible after your admission, in a format you can understand and engage with. They must support you to be involved in discussions and decisions about your ongoing care needs and future care options. If you have difficulty participating due to disability, impairment or sensory loss, they must arrange appropriate support. This can be a British Sign Language interpreter, lip reader, deaf blind interpreter or advocate. If English is not your first language, ask staff to arrange an interpreter to support you.

If you find it difficult to understand information and make decisions and have no family or friends to support you, staff must arrange for an independent advocate. Their role is to explore your feelings and what you would like and help find out what would be in your best interests.

Expected date of discharge (EDD)

Once doctors decide what treatment you need, they should have an idea, usually within 48 hours of admission, of your likely discharge date. They should share it with you (your partner and/or family or care home) as soon as they know it, review it regularly and share any changes with you. Your expected date of discharge may be referred to or written down as your EDD.

You should not be discharged until the doctor in charge of your care says you are medically fit and safe to be discharged and the care package and equipment you are assessed as needing are in place.

5.1 Considering need for short-term support

Before considering long term needs, doctors may agree you would benefit from a programme of support, provided for a limited period, so you continue your recovery or regain the ability and confidence to live as independently as possible. Intermediate care and reablement, described in section 8.1, offer such support. After an agreed period of up to six weeks, during which you receive specialist support and work towards goals you and staff agree are appropriate, staff must re-assess your needs to see if further short or long term support is required.

5.2 Considering eligibility for NHS continuing healthcare

Due to the nature, complexity, intensity or unpredictability of your needs, you may be eligible for NHS continuing healthcare (NHS CHC).

It may not always be appropriate, but in most cases, it is preferable to consider eligibility after discharge. It can be difficult to accurately reflect your on-going needs on a busy hospital ward and appropriate short term support, such as intermediate care, can enable you to recover further before being considered. For information, see section 8.6.

5.3 Assessing need for long-term support

If it appears you will need help and support on leaving hospital, and staff do not believe you would benefit from short term support or should be considered for NHS CHC, you have a right to a local authority needs assessment, regardless of your financial situation.

Co-ordinating your discharge and needs assessment

If your needs are complex, you should have a named, discharge co-ordinator to manage your discharge. They should be your central point of contact, keep you (and your carer/family) informed of steps being taken to identify your needs and involve you in decisions about ongoing care.

Tell them about your home environment, any difficulties you had managing at home prior to admission and whether you were receiving a home care package. Tell them if you care for your partner or a family member and intend to resume caring when you leave hospital. They should take these things into account during your assessment.

Important things to consider when having a needs assessment

The assessment should involve you, appropriate NHS and social care staff such as the hospital social worker and family members or friends who act as your carer. If you have a carer, staff must assess you as if they do not, to establish your underlying eligibility for care and support.

The aim is to identify any NHS services you need on discharge, find out what care and support you think you need and whether you can do certain activities. This includes daily living activities such as washing and dressing, managing the toilet, managing and maintaining good nutrition, keeping your home in a habitable condition and activity that contributes to your wellbeing, such as keeping in touch with family and friends and making use of local transport and services.

In deciding eligibility, the ability to complete such activities is described as '**achieving desired outcomes**'. Staff must consider the ease or difficulty with which you manage these things, if you need help, whether doing them takes a lot longer than normal, causes pain or anxiety or puts someone else's safety at risk.

To be eligible, your needs must relate to a disability or illness. You must be unable to achieve at least two '**desired outcomes**' in your day-to-day life and this must have a significant impact on your wellbeing. When making their decision, it is your ability to do these tasks that is important. Staff must ignore the fact a carer may do some tasks for you. For more information, see factsheet 41, *How to get care and support*.

Parts of England have introduced a **discharge to assess (D2A)** system for some patients. This approach helps minimise time spent in hospital and can maintain mobility and confidence which can be lost if discharge is delayed.

5.4 Assess your carer's needs and eligibility for support

If you already receive help from a partner or informal carer or they propose to help when you are discharged, they have a right to an assessment if providing *necessary* support, and to have a support plan if found eligible.

If not eligible, staff should explain why and give your carer information about organisations that can help. If they cannot complete the assessment or review the support plan before your discharge, it should take place as soon as possible so your carer gets the support they are entitled to.

For more information, see factsheet 41, *How to get care and support*. Carers UK offers information for carers.

5.5 Discharge planning and arranging care

Once your needs assessment is complete, the discharge co-ordinator discusses the outcome with you, your carer or family where appropriate, the options for meeting your needs and whose responsibility this is.

When your local authority has a duty to meet your needs

If you have eligible needs, staff ask about your financial situation to see if you are eligible for local authority help towards the cost of your care. If it appears you are, it carries out a detailed means-test to decide how much you should contribute. For information see section 7.

The next step is for staff to work with you (and family members if appropriate) to produce a care and support plan describing where and how your needs are to be met and any aids or equipment you need. Staff should involve you in discussions as much as you wish or are able, take account of your wishes and wellbeing and make you aware of your choices.

If you wish to go home and you have a partner or informal carer, staff should discuss with you both whether your carer is able and willing to start or continue providing care or take on additional tasks. Staff should identify and arrange any training to help them.

Care planning can be used to explore whether a move to a care home is appropriate. You cannot be forced to move to a care home, as long as you are mentally capable to make that decision. Staff may advise it is the only safe and effective way to meet your needs.

You can ask staff to explore other ways to meet your needs and consider your potential for further recovery if offered short term tailored support. You may wish to argue and provide evidence that a care home will not meet your needs, including psychological needs. Care planning decisions should not be made on arbitrary financial considerations.

You may have needs that could be met by '*universal services*'. These are services generally available to anyone and may include help from a voluntary organisation or involve joining a walking group or club.

The local authority can decide to meet needs that do not meet eligibility criteria if, for example, they may quickly get worse or tell you about services to prevent care needs getting worse.

When you must make your own care arrangements

If you have eligible needs, the local authority must ensure these are met. If your financial resources are above the means-test limits, it does not have a duty to put arrangements in place for home care or a care home placement. You are expected to arrange and meet the costs of care yourself. You are a '*self-funder*'. For information see section 7.

In these circumstances, you or your family are entitled to know the findings of your assessment and be given information and advice to help you understand your care needs and options open to you.

This includes details of:

- the care system and how it works locally
- types of care and support and choice of local care agencies/care homes
- ways to pay for care and how to access independent financial advice to discuss ways of paying for care.

Staff should tell you about ways to prevent your needs getting worse.

As a *self-funder*, you can choose to ask the local authority to arrange your home care package. They must agree to your request but can charge you for the cost of services and charge an arrangement fee as well. As a *self-funder* you cannot ask them to arrange a care home place.

Note

An exception to the above and the only time a local authority must arrange home care (without an administration fee) or a care home place for a *self-funder* is if you do not have capacity to make your own arrangements and have no one to help you.

If your needs do not meet eligibility criteria

If your needs do not meet eligibility criteria, staff must give you a written record of the decision and reasons for it. If you think this is wrong, you can ask them to reconsider or challenge their decision.

Staff should provide you with appropriate information and advice to help you meet your own needs. This could be information about local domestic or care agencies or suitable local voluntary organisations that offer care and support, such as your local Age UK and how you could prevent care needs from developing or getting worse.

6 Practical issues when leaving hospital

Attention to practical issues is vital for a safe and smooth discharge:

- has your carer been given sufficient notice of your discharge date/time?
- do you have, and are you wearing, suitable clothes for the journey home?
- is a relative collecting you or is hospital transport required?
- do you have house keys and money if travelling home alone?
- will medication be ready on time? This is usually enough for the next seven days. Has your medication changed since admission? Have changes been explained to you and your carer? Do you know whether some prescribed items are only to be taken in the short term?
- have you and your carer received training to use new aids or equipment safely and effectively? Will they be there when you get home?
- do you have a supply of continence products to take home as agreed, know when to expect the next delivery and how to order supplies?
- is your GP and other community health staff aware of your discharge date and support you need from them? Has a discharge summary with details of any medication changes been forwarded to the practice?
- if returning to your care home, has the manager been informed of the date and likely time of your arrival? Are you to take a copy with you or will staff forward copies of your care plan and medication needs to them promptly?

Your discharge plan

Staff should produce a discharge plan, give a copy to you and forward one promptly to your GP and care home if that is where you are discharged to.

A discharge plan includes information such as:

- details about your condition
- information about medicines
- contact information after discharge - who to contact and how to contact them with any questions about your care
- arrangements for continuing social care support, aids and equipment
- arrangements for ongoing health support.
- details of useful community and voluntary organisations.

7 Paying for care

This is a complex area and this section provides basic information. To understand the situation fully, please read factsheets noted below.

7.1 Paying for care at home

Your local authority carries out a means-test to decide how much you should contribute to your care costs. This takes account of your capital, savings and income but must ensure, having paid your required charge, your weekly income does not fall below a certain level. Savings below £14,250 are not counted.

If you have eligible needs and are eligible for financial support, you are allocated a '*personal budget*'. This is how much money they consider it costs locally to meet your needs. They must explain how they calculate it. You can choose to have this as a *direct payment* and arrange your own care instead of asking the local authority to arrange it for you.

The *direct payment* scheme allows people lacking capacity to consent to or manage a personal budget to have one. The local authority appoints a suitable person willing to receive and manage a direct payment on behalf of the person lacking capacity. This can be a family member or friend.

For information see factsheet 24, *Personal budgets and direct payments in social care* and factsheet 46, *Paying for care and support at home*.

7.2 Paying for care in a care home

The local authority carries out a means-test to decide how much you must contribute to the cost of a care home place. It takes account of your capital, savings and income. The value of your house is disregarded if your partner or certain family members live there. Savings below £14,250 are not counted.

If you have eligible needs and capital under £23,250, the local authority calculates how much you and it must pay towards your fees. Staff allocate a '*personal budget*', a sum the local authority considers it costs in the local area to meet your eligible needs in a care home.

If you have over £23,250, you must arrange and pay for your care home place (unless you lack capacity to do this and have no one else who can help you, in which case the local authority must arrange it for you).

If your capital is coming down to £23,250, it is advisable to let the local authority know at least three months before reaching it, to allow time to carry out a financial assessment.

For more information see factsheet 10, *Paying for permanent residential care*, factsheet 29, *Finding, choosing and funding a care home*, factsheet 38, *Property and paying for residential care*, and factsheet 39, *Paying for care in a care home if you have a partner*.

8 Options on discharge

8.1 Short term support

Intermediate care and reablement offer a period of time-limited support and aim to help re-build your confidence and maximise your ability to live independently. It is important for staff to consider this type of support, particularly if your current needs suggest a permanent place in a care home is a serious possibility.

Intermediate care, including reablement is designed to achieve one or more of the following:

- support timely discharge from hospital and help you be as independent as possible, or
- maximise your potential for further recovery and prevent you moving into permanent residential care before you really need to, or
- maximise your potential for further recovery before considering your eligibility for NHS Continuing Health Care, or
- help you avoid going into hospital unnecessarily.

If staff believe you can achieve jointly agreed goals, the local authority must not charge for this support for up to and including six weeks.

Local authorities can use discretion to offer this support free of charge for longer than six weeks, where there are clear preventative benefits. This might be if you have recently become visually impaired or you have dementia and staff believe you have potential to be able to continue living at home if this type of support is available for longer.

Intermediate care at home, in a care home or community hospital

Staff discuss with you, and where appropriate your family, what they hope you could achieve within an agreed time frame and agree a care and support plan. Depending on your needs, this can involve a range of professionals such as nurses, physiotherapists and help with personal care. You may be given aids and equipment to use.

Reablement

Reablement offers support in your own home from specially trained care workers. The aim is to support and encourage you to learn or re-learn skills necessary for daily living and help you discover what you can do for yourself. The goal is to regain as much independence as possible.

Staff discuss and agree with you what they believe you could achieve within an agreed time frame, up to and including six weeks. This might include becoming more confident when moving around your home, using the toilet and with tasks such as washing, dressing and preparing meals.

Review following a period of intermediate care or reablement

At the end of your initial period of intermediate care or reablement, staff should review progress to see if you have achieved your goals and what else could be achieved if they allow more time. Once it is agreed no further improvement is likely, you (and where appropriate your family and carers) must, in the light of your current needs, discuss potential longer term options and agree a care plan. The local authority carries out a means-test to see if you need to pay towards the cost of future care.

If you are offered intermediate care prior to commencing the process to decide NHS CHC eligibility and staff decide no further improvement is likely, they must initiate the procedure described in section 8.6.

For information see factsheet 76, *Intermediate care and reablement*.

8.2 NHS services

Whether your ongoing care means you live at home or in a care home, you can receive and should not be charged for:

- support from your GP and community-based staff such as district nurses, continence nurses, dietitians and community mental health nurses
- continence pads and related products identified as necessary during your assessment
- specialist nursing and other medical equipment
- respite health care. You are eligible for NHS funded respite care if you have intensive or complex health care needs requiring specialised or intense nursing attention. NHS funded respite care may be appropriate if you would benefit from active rehabilitation during a period of respite. In most cases, respite care is to enable you and a carer who provides regular care to have a break. It is usually viewed as a social care rather than NHS responsibility and may be means tested.

Rehabilitation and recovery services

Rehabilitation services aim to promote your recovery and maximise your independence, for example, after a heart attack, stroke, or acute attack of a long term illness such as multiple sclerosis. Services begin while you are in hospital and can continue for weeks or months once you leave. You may receive support, as an individual or in a group, from a range of health professionals, including physiotherapists, occupational therapists or speech therapists. Speech therapists can help with both speech and swallowing difficulties.

After a heart attack, staff should tell you about local rehabilitation services and encourage you to attend. Before leaving hospital after a stroke, you should work with your care team to set goals you would like to achieve on leaving hospital and identify the support you need to reach them. Rehabilitation has a similar purpose to intermediate care but differs in that it starts in hospital and is not time limited.

Self-management support

If you have one or more long-term conditions, NHS staff should help and encourage you to be more involved in your care. On-going support from your hospital team, GP, practice or specialist nurse can give you confidence to take decisions about your day-to-day care and recognise changes to report promptly to your GP. There is information about many health conditions on NHS Choices website.

There may be local self-management courses, running over several weeks. These can give you the confidence, skills and knowledge to self-manage your condition and an opportunity to learn from and support others. Your consultant, specialist nurse, GP or NHS Choices website may have information about local courses.

8.3 Going home

With a care package

This may be arranged and funded with local authority help or by you, as described in section 7.1.

Help at home with domestic tasks

You may only need a help with domestic tasks for a few weeks after planned treatment or a short hospital stay. This can be provided by a partner, family or friends coming to stay, or private agencies.

If you live alone, many areas offer a '*home from hospital*' service for between two and six weeks. This could be someone to help you settle back home and sort out paperwork that arrived while you were in hospital or help with light housework and shopping. They aim to keep in touch, have a chat and check you are managing on your own. Such support is usually free of charge. The hospital may arrange it and ask agencies, including Age UK or the Red Cross, to deliver it or these agencies may deliver their own free or charged for service.

Help from voluntary sector organisations

Voluntary organisations such as Age UK, Royal Voluntary Service and British Red Cross offer a range of local services. They may offer:

- meals-on-wheels
- lunch clubs and day centres. You may need a referral from social services to attend a day centre or lunch club
- home visiting and telephone befriending
- handyperson schemes – help with minor jobs around the home
- the loan of equipment such as wheelchairs and commodes
- information and advice
- non-residential respite care.

Help from private care agencies

Private care agencies help with personal care, domestic tasks and meal preparation and may provide care from a registered nurse. They must register with and are inspected by the Care Quality Commission (CQC). The CQC website publishes care agency inspection reports.

If paying for your own care, you may decide to buy services from an agency. If you receive a direct payment from social services, you can choose to use an agency. Your local authority has details of local agencies and UK Home Care Association has a list of member agencies, including those providing live-in carers.

8.4 Moving to a care home

In the light of your needs, a move to a residential home or a nursing home may be the only safe and effective option.

Age UK *Care home checklist* has a list of issues to think about and questions to ask when choosing a care home.

If your local authority is to help fund your care home, it should provide a list of suitable homes to view, offering you at least one choice at your personal budget level. You have a right to choose a more expensive home if someone is willing and able to pay a '*third party*' top up to make up the difference between the personal budget and the actual fees.

You should not be asked to pay a '*third party*' top up if there are no homes available at your personal budget amount. In general, you cannot pay the top up yourself; it must be a third party such as a family member or friend. The exceptions to this rule are explained in factsheet 29 *Finding, choosing and funding a care home*.

If *self-funding* your care home, you have a free choice of home. It is important to be mindful of how long your money will last before you need to apply for local authority help with fees, as referred to in section 7.2.

Check the terms and conditions of the contract the home asks you to sign, as in some cases there are terms that apply should your money run out and you need to apply to the local authority for financial support. Ask a potential nursing home how they reflect the NHS-funded nursing care payment in their fees and explain it in their terms and conditions.

If staff propose you move permanently to a *nursing home* on discharge and do not believe intermediate care is appropriate, they should consider whether you might be eligible for NHS CHC, described in section 8.6. If unsure, they should complete the '*checklist tool*', before deciding your need for NHS-funded nursing care. The latter is a payment the NHS agrees to make to nursing homes on behalf of a resident, as a contribution towards care provided by registered nurses employed by the home.

8.5 Waiting for assessments or your chosen option

There will be a hospital policy that applies if you are medically ready for discharge but are waiting for completion of assessments or funding agreements to be made; if there is no intermediate care or reablement available; no vacancy at your chosen care agency or your chosen care home; or you have yet to choose a care home or home care agency.

This is likely to involve offering an interim care package that meets your assessed needs. The discharge coordinator should explain your options, if there is to be a charge and discuss any concerns.

8.6 NHS Continuing healthcare

NHS continuing healthcare (NHS CHC) is a package of care funded solely by the NHS, when it is shown your need for care is primarily a health need. Staff must follow the National Framework for NHS CHC and NHS-funded nursing care to decide eligibility. You can receive NHS CHC in your own home, a care home or other suitable location.

If staff are unsure or believe you may be eligible, the first step is to complete, with your permission and involvement, the Framework's '*checklist tool*'. This aims to identify if you need a full assessment to decide eligibility. If you do not have mental capacity to consent, those making a best interests decision on your behalf should bear in mind the expectation that everyone who is potentially eligible should have the opportunity to be considered.

If the *checklist* does not trigger a full assessment, staff should ask if you want them to arrange a local authority needs assessment. You can ask for the checklist decision to be reconsidered.

A positive *checklist* indicates you should have a full assessment but does not mean you will be eligible. Staff should tell you the checklist result, record it in your notes, seek your consent to carry out a full assessment looking at your physical and mental health needs, and enable you and/or your representative to be involved. A multidisciplinary team then uses assessment information to complete a second tool – the '*decision support tool*' which informs their recommendation about your eligibility.

Staff should tell you the outcome in writing, with reasons, and explain how to lodge an appeal if you disagree with the decision.

There is a '*fast-track tool*' to use if you have '*a rapidly deteriorating condition that may be entering a terminal phase*'. This must be completed by an appropriate clinician, who may recommend you move quickly onto NHS CHC. The NHS should act immediately on this recommendation, so necessary care and support is in place, ideally within 48 hours.

For more information, see factsheet 20, *NHS continuing healthcare and NHS-funded nursing care*.

8.7 Palliative care support

You can be offered palliative care services when diagnosed with a progressive illness that cannot be cured. Originally only offered to people with incurable cancer, in many parts of the country it is now available for other life limiting conditions.

Palliative care aims to keep you comfortable and ensure the best quality of life at all stages of your illness. A range of services can be available when you receive a diagnosis and be on hand, as and when you need them. This might be emotional support for you and your family or help to control and manage pain and other physical symptoms.

You can receive support while living in your own home or a care home, in a hospice or in hospital. It may involve doctors, nurses, hospice staff or 'hospice at home' teams, Marie Curie nurses and posts supported by Macmillan. Your GP refers you, if you need support at home.

You may want to discuss how you would like to be cared for as you approach the end of your life with health professionals caring for you. You can involve your family or friends if you want. This is known as 'advance care planning' and means all those caring for you are aware of your wishes. The National Council for Palliative Care booklet *Planning your future care* explains more.

If you have a rapidly deteriorating condition that may be entering a terminal phase, ask if you should be 'fast tracked' onto NHS CHC.

8.8 Sheltered housing or adapting accommodation

Your hospital stay may raise questions about the long term suitability of your home. Realistically, structural adaptations to your home or a move to sheltered housing may be longer term solutions. To allow for a timely discharge, you may need to consider other options in the interim.

For more information, contact EAC FirstStop Advice or see Age UK guides *Housing options* and *Adapting your home*, factsheet 2, *Buying retirement housing* and factsheet 8, *Council and housing association housing*.

9 Reviewing your care and support needs

If the local authority funds your care package, you should know who to contact with any concerns and it should keep your care and support plan under review. You usually have a light touch review six to eight weeks after a package begins and then at least every year. If your care package no longer meets your needs, contact your local authority and ask for a reassessment.

10 Providing feedback on discharge

Hospitals must ask all patients over the age of 16 who have attended A&E or stayed overnight on a ward to respond anonymously to a simple Friends and Family Test question – *‘would you recommend the A&E department or ward where you were an inpatient to your friends and family who needed similar care or treatment?’*

They ask you to reply within 48 hours of discharge and record your answer on a scale ranging from *‘extremely likely’* to *‘extremely unlikely’*, as well as a *‘don’t know’* option. The hospital can ask additional questions to discover more about your chosen rating, such as *‘Please give the main reason for the score you have given’*.

Your answer helps pinpoint elements of a good experience as well as one that was poor. Such feedback lets hospitals see where things are working well and monitor improvements. It allows them to pick up and respond to trends suggesting a poor experience in certain wards and investigate and respond promptly

The hospital can choose how to collect feedback and use any of the following - a postcard, touch-screen kiosks in the hospital, or digitally online or via smartphones. You can find results for your local hospital on www.nhs.uk/NHSEngland/AboutNHSservices/Pages/nhs-friends-and-family-test.aspx

Do not view the Friends and Family Test as a substitute for raising concerns at the time or for making a formal complaint.

11 Raising concerns or making a complaint

If you have problems as an inpatient or around the time of discharge, try to raise them at the time with the staff concerned. If this does not resolve them, ask the hospital Patient Advice and Liaison Service (PALS) if they can intervene for you. If this does not produce the desired result, you can make a formal NHS complaint. Ask PALS to explain the process and for contact details of the local NHS complaints advocacy service. This is a free, independent service to help you through the complaints procedure.

If your complaint is about services provided by a care agency or care home, complain directly to them. If you are unhappy with their response and social services arranged the services, raise this with social services. If you arranged services yourself, you can raise your complaint with the Local Government and Social Care Ombudsman.

If your complaint relates to both NHS and social services (a complaint about hospital discharge may well involve both), you need only make one complaint, covering all issues, to either the hospital or social services. The organisation receiving your complaint must approach the other organisation and between them ensure you receive a single response addressing all the points you made.

The Care Quality Commission registers and inspects care agencies, care homes and hospitals and requires them to have a complaints procedure. It does not investigate individual complaints but encourages people to share good and bad experiences with them by phone, letter or 'share your experience' form on their website. For information see factsheet 59, *How to resolve problems and complain about social care* and factsheet 66, *Resolving problems and making a complaint about NHS care*.

12 Hospital discharge – legislation and guidance

12.1 Legislation addressing hospital discharge

- **The Care Act 2014**

www.legislation.gov.uk/ukpga/2014/23/contents/enacted

- **The Care and Support (Discharge of hospital patients) Regulations 2014** www.legislation.gov.uk/uksi/2014/2823/pdfs/uksi_20142823_en.pdf

The regulations describe the process followed when discharging adults from an 'acute hospital bed' who are to be supported by social services. A patient in an acute hospital bed is likely to have had planned treatment or surgery or been admitted as an emergency. They do not apply to mental health care where the person primarily responsible for your care is a consultant psychiatrist; palliative care; intermediate care; or non-acute care in a community hospital or step down bed.

- **Care and Support Statutory Guidance issued under Care Act 2014**

www.gov.uk/guidance/care-and-support-statutory-guidance

12.2 NICE and other guidance

NHS organisations are encouraged to follow NICE recommendations to help them deliver high quality care and should take best practice guidance into account when planning services. Choose 'information for the public'.

- **Transition between inpatient hospital settings and community or care home settings for adults with social care needs** NICE guideline published December 2015. www.nice.org.uk/guidance/ng27

- **Quick guide: supporting patients' choices to avoid long hospital stays** March 2016 www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-supporting-patients-choices.pdf

- **Quick guide: Improving hospital discharge into the care sector**

published NHS England Gateway reference 04253

www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-Improving-hospital-discharge-into-the-care-sector.pdf

with **Hospital discharge and NHS continuing healthcare flowchart**

www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/background-docs/76-CHCmythbusterv3.pdf

Useful organisations

Alzheimer's Society

www.alzheimers.org.uk

Telephone helpline 0300 222 11 22

Provides information about all types of dementia and supports people, their families and carers including a range of factsheets.

British Red Cross Society

www.redcross.org.uk

Telephone 0344 871 11 11

Services include transport and escort, medical loan, emergency response, fire victim's support, domiciliary care, Home from Hospital schemes and first aid mainly provided by volunteers from local centres.

Carer's Direct

www.nhs.uk/Conditions/social-care-and-support-guide/Pages/carers-direct-helpline.aspx

Telephone helpline 0300 123 1053

Offers information, advice and support to carers.

Carers Trust

www.carers.org

Telephone 0300 772 9600

Offers information, online forums and support for carers.

Carers UK

www.carersuk.org

Telephone 0808 808 7777

Provides information and support for carers.

Care Quality Commission

www.cqc.org.uk

Telephone 03000 61 61 61 (free call)

Independent regulator of adult health and social care services in England, covering NHS, local authorities, private companies or voluntary organisations and people detained under the *Mental Health Act*.

Disability Benefits Helpline

www.gov.uk/disability-benefits-helpline

DWP helpline providing advice or information about claims for Disability Living Allowance, Personal Independence Payment or Attendance Allowance already made.

Attendance Allowance

Telephone 0800 731 0122

Disability Living Allowance

Telephone 0800 731 0122 if you were born on or before 8 April 1948

Telephone 0800 121 4600 if you were born after 8 April 1948

Personal Independence Payment

Telephone 0800 121 4433

EAC FirstStop Advice

<http://hoop.eac.org.uk/hoop/start.aspx>

Telephone helpline 0800 377 7070 (to request email advice)

Provides information on housing options for older people and signposts to relevant advice organisations.

Macmillan Cancer Support

www.macmillan.org.uk

Telephone helpline 0808 808 00 00

Provides information, advice and support for people with cancer, their families and carers.

Marie Curie

www.mariecurie.org.uk

Telephone 0800 090 2309

Offers expert care guidance and support to people living with any terminal illness and their families.

NHS Choices

www.nhs.uk/Conditions/social-care-and-support-guide/Pages/hospital-discharge-care.aspx

Government website that provides information on health conditions and a guide to care and support.

National Council for Palliative Care

www.ncpc.org.uk

Telephone 020 7697 1520

The umbrella charity for all involved in palliative, end of life and hospice care in England, Wales and Northern Ireland.

Royal Voluntary Service

www.royalvoluntaryservice.org.uk/

Telephone 0845 608 0122

Provides services for older people through the activities of its volunteers.

UK Home Care Association

www.ukhca.co.uk

Telephone 020 8661 8188

The professional association of home care providers from the independent, voluntary, not-for-profit and statutory sectors.

Age UK

Age UK provides advice and information for people in later life through our Age UK Advice line, publications and online. Call Age UK Advice or Age Cymru Advice to find out whether there is a local Age UK near you, and to order free copies of our information guides and factsheets.

Age UK Advice

www.ageuk.org.uk

0800 169 65 65

Lines are open seven days a week from 8.00am to 7.00pm

In Wales contact

Age Cymru Advice

www.agecymru.org.uk

0800 022 3444

In Northern Ireland contact

Age NI

www.ageni.org

0808 808 7575

In Scotland contact

Age Scotland

www.agescotland.org.uk

0800 124 4222

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