

Factsheet 37

Hospital discharge

August 2017

About this factsheet

This factsheet explains how your discharge from hospital should be managed following NHS treatment. The aim should be for you to stay in hospital no longer than necessary and to receive the ongoing care and support you need in the most appropriate place.

You may find it helpful to read other Age UK factsheets on help available from your local authority social services department, home care and care home funding, 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 organisations 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 for those close to you, but it is likely to be less stressful if you know what to expect.

If your admission is *planned*, your hospital stay and abilities on leaving hospital are more predictable. When agreeing to treatment, asking the doctor what you can expect afterwards, allows you to plan ahead.

An *emergency admission* brings more uncertainty but there are steps staff should follow to ensure you do not stay in hospital longer than necessary and receive the right care and support when medically ready to leave.

This factsheet covers issues around a hospital stay but the main 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.

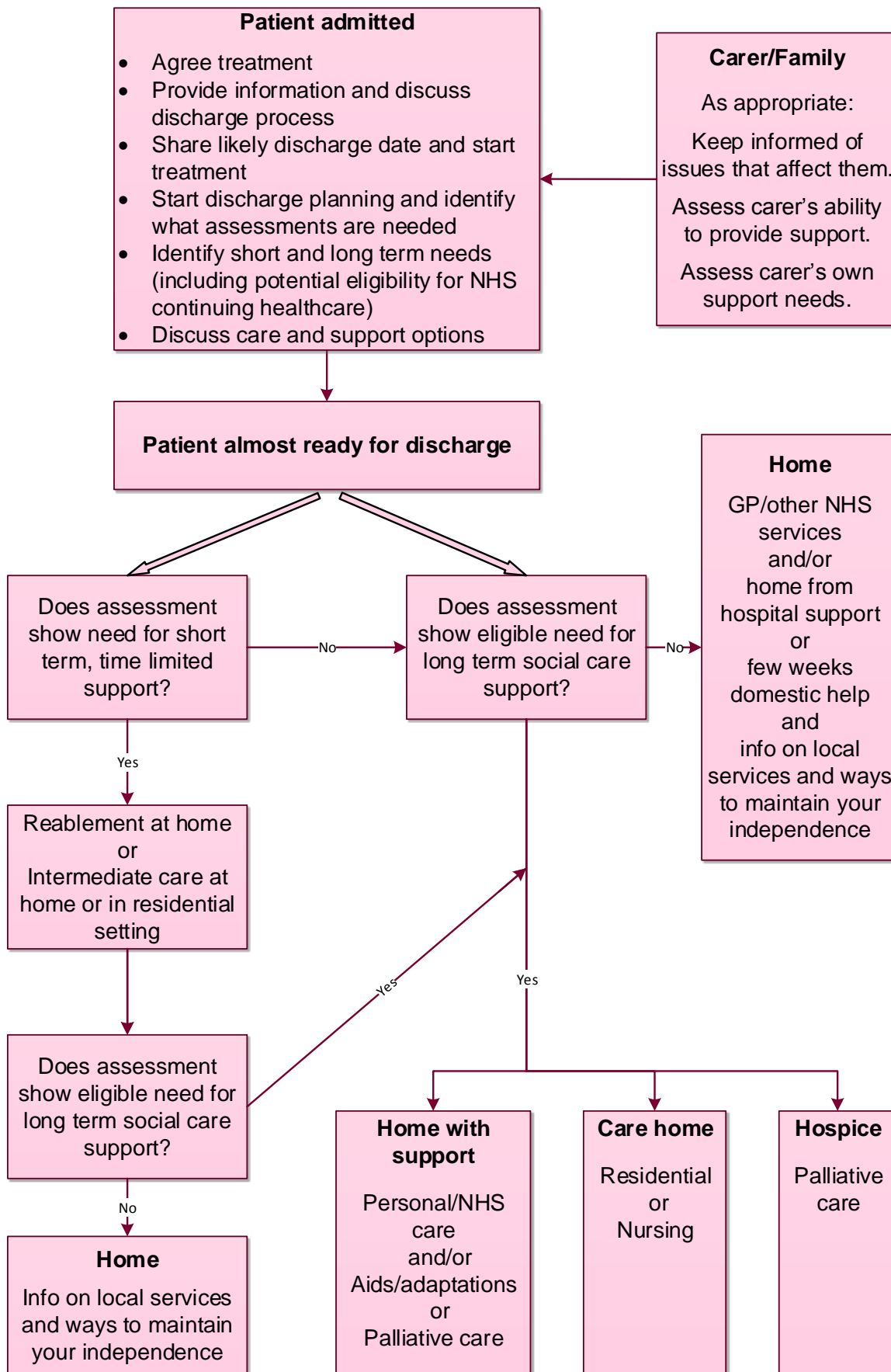
2 Hospital discharge – key steps

Staff should:

- 1 Provide you with information about the discharge process in a format you can understand and engage with.
- 2 Start planning for your discharge 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) at all stages.
- 3 Share your likely date of discharge 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 your assessed needs mean you are eligible for local authority support, consider your views on how to support you, discuss your options and agree and draw up a care and support plan with you.
- 7 If eligible for local authority support, assess your ability to pay towards the cost.
- 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 information about on-going health needs and medication goes promptly to your GP and other NHS staff.
- 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 referral leads to an invitation to attend an outpatient appointment to explore or confirm your diagnosis and discuss treatment options.

The GP referral should tell the hospital about your communication needs. This might mean sending appointment letters and information in large print, easy read, Braille or audio. It might mean the hospital needs to 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? How long before I can have them? How long before I get the results and how will I get them?
- What are the benefits, side effects, risks and success rates of each treatment option?
- What improvements can I expect in my condition or day to day life after each of the treatment options? When might I start to notice improvements and when can I expect a full recovery?
- Will tests or treatment require me to be an inpatient or day patient?
- What is the likely length of my hospital stay?
- What would be the consequences of doing nothing or waiting a while?
- What treatment would you recommend and why?
- 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).

It is important to tell staff about your home environment and any help you receive from social services. The more staff know before you have treatment, 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 Accident and Emergency (A&E) does not always result in admission to hospital.

Following an appropriate assessment and initial treatment by ambulance paramedics or A&E 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 A&E departments can contact a '*crisis response team*' who arrange short term (48 – 72 hour) health and/or social care support at short notice. These interventions can prevent unnecessary trips to A&E and hospital admissions, or
- A&E staff may move you 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 for the NHS to create one from your GP record. It contains up-to-date information about medicines you are taking, those you react badly to and any allergies.

If you cannot communicate with staff when you arrive at A&E, 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 and they must first ask your permission.

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

Staff should look at the main reason for your admission but also 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 noticed unintended weight loss or your memory or thinking skills are causing problems.

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

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 with your care providers, including end of life care and be given information and support to allow you to do this. Where appropriate this includes 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 you are 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.

Note

To read about the NHS Constitution and your rights, see www.gov.uk/government/publications/the-nhs-constitution-for-england

4.2 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 staff provide appropriate care and helps you to get maximum benefit from a hospital stay.

Let staff know what name you like to be called, about sight or hearing difficulties, usual routines, food preferences, need for help with eating and drinking, sleeping patterns and preferences, any 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*'. You can get a copy 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/>

4.3 Involving your family or carer

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 be told if you have appointed someone to act on your behalf using a Lasting Power of Attorney (health and care decisions). Your attorney must act on your behalf if, due to lack of mental capacity, you are unable to make your own treatment decisions or decisions about ongoing care at the time they need to be made.

Your carer should receive information from hospital staff to enable them to safely carry out tasks they agree to undertake on your behalf once you go home. If family members will be responsible for making arrangements to meet your ongoing care needs, they should be given information to help understand the type of care they should look for.

4.4 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 this information with other professionals.

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

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 make arrangements 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*.

4.5 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 Guarantee Credit, losing these benefits may affect the amount of Pension Credit you receive. Payment of these benefits should resume when you are discharged from hospital.

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 you, or an insurance plan, funds planned treatment in a private hospital, ask the consultant about the hospital's discharge procedure. Find out if personal care or other daily tasks might be a problem for you and whether you might benefit from aids to help with mobility or ensure your safety.

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. They may ask you to contact them again once you are 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 social services support, you could 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 provide 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.

Staff must support you to be involved in discussions and decisions about your 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, staff should involve an interpreter.

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 want 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. As soon as they know it, they should share it with you (your partner and/or family or your care home). They should 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 your long term needs, doctors may decide you would benefit from support to continue your recovery or regain confidence and your ability to live as independently as possible. Intermediate care and reablement offer such support (see section 8.1). At the end of the agreed period during which you work towards agreed goals, staff must re-assess you to see if you need further short or long term support.

5.2 Considering eligibility for NHS Continuing Health Care

Some patients due to the nature, complexity, intensity or unpredictability of their needs, may be eligible for NHS Continuing Healthcare (NHS CHC). NHS CHC is a NHS funded care package, if it is established their primary need for care is a health need. Staff must follow a specific assessment procedure if they think you may be eligible. There is a 'fast track tool' should staff think you have a rapidly deteriorating condition that may be entering a terminal phase.

You can receive NHS CHC in different places including your own home or a care home.

If staff believe you could benefit from short term intermediate care, it is recommended you receive this *before* staff consider your eligibility for NHS CHC. Where possible, your NHS CHC assessment should take place away from a busy acute hospital ward.

Discharge staff can provide information about NHS CHC. For information, see section 8.3.1.

5.3 Assessing need for long-term support

If you are not to be considered for NHS CHC but it appears you will need help and support on leaving hospital, you have a right to a needs assessment, regardless of your financial situation.

Co-ordinating your discharge and needs assessment

A member of the ward team is responsible for managing your discharge. If your needs are complex, this is likely to be a bespoke discharge co-ordinator. They should be your central point of contact and keep you (and your carer/family) informed of steps being taken to identify your needs and involve you in decisions about your ongoing care. You should know their name and a named replacement should cover in their absence.

Tell discharge staff 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 staff, social care staff such as the hospital social worker and family members or friends who act as your carer. You can ask for family members to be involved and staff can gain valuable insight by talking to family and close friends.

The aim is to identify any NHS services you need on discharge, find out how you see your care needs and whether you can do certain activities. This includes daily living activity 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 for social services care and support, 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. They must have a significant impact on your wellbeing. When making a 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. Once medically fit for discharge, short term support is provided so you can be discharged to your own home, with health professionals such as occupational therapists or physiotherapists undertaking an assessment within a defined time period. 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 your partner or an informal carer helped you before your hospital admission or proposes to help when you leave, they have a right to their own assessment if they provide necessary support.

A carer's assessment looks at the effect of caring on a carer's wellbeing and ability to continue to care. It looks particularly at how it affects their ability to care for and look after other members of their family, maintain their own home in a habitable state, maintain family and personal relationships, go to work or college or volunteer and make use of local community and recreational facilities. They call these '**desired outcomes**'.

Staff consider the ease with which a carer can manage these things, whether it causes pain or anxiety and whether although managing to do these things, other people are put at risk.

Staff compare a carer's needs with eligibility criteria to decide their eligibility for social services support. To be eligible, their needs must be connected with providing necessary care, mean their physical or mental health is deteriorating or at risk of deteriorating, they cannot achieve one of the '**desired outcomes**' and this significantly affects their wellbeing.

If your carer is eligible for support, the local authority works with them to produce a care plan that describes the support agreed. If they are not eligible, they should be told why and given information about other organisations that can help them.

Social services may not be able to complete your carer's assessment or review a current support plan before you are discharged. It is important this takes place as soon as possible after discharge to ensure your carer gets the support they are entitled to. Carers UK offers a range of information for carers.

5.5 Discharge planning and arranging care

Once your assessment is complete, the discharge co-ordinator works with you, your carer (and family where appropriate) and often the hospital social worker and NHS staff, to consider options for meeting your care needs and to decide who is responsible for meeting them.

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 with paying towards the cost of your care. If it appears you do, your local authority carry out a detailed means-test to decide how much you should contribute. 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 how and where 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 and make sure you are aware of your choices. If the intention is for you to go home and you have a partner or informal carer, your eligible needs are identified without reference to them. Staff should discuss with you both whether or not your carer is able and willing to continue providing or take on additional caring tasks or to start to provide care. If they are, staff should identify and arrange any training that would help them.

Care planning can be used to explore whether a move to a care home is an appropriate option. You cannot be forced to move to a care home if you do not want to, as long as you are mentally capable of making that decision. Staff may advise it is the only safe and effective way to meet your needs. If you do not want to move into a care home, ask for other ways to meet your needs to be explored, including short term support to explore your potential for further recovery.

Care planning decisions should take account of your wishes and wellbeing and not be made on arbitrary financial considerations. You may wish to argue and provide evidence that a care home will not meet your needs, including psychological needs.

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, community centre or faith group 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, it believes those needs may get worse quite quickly if they do not offer support now. You should be told about local services that offer general support and those that could stop your 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. This is called being a '*self-funder*'. See section 7.

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.

They should also tell you about ways of preventing your needs from getting worse.

As a *self-funder* you can choose to ask the local authority to arrange your home care package. If they agree to, they can charge an administrative fee. As a *self-funder* you cannot ask them to arrange a care home place for you.

Note

An exception to the above and the only time a local authority must arrange home care or a care home place for a *self-funder* is if they do not have capacity to make arrangements themselves and have no one to help them.

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 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 other factsheets noted below.

7.1 Paying for care at home

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

If you are eligible for local authority support, they allocate a '*personal budget*'. This is a sum of money they consider it costs in the local area to meet your eligible needs and they must explain how this amount is calculated. You can choose to have this as a *direct payment* and arrange your own care instead of asking the local authority to arrange care and support services for you.

A *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 more 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

Your local authority carries out a means-test to decide how much you have to 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 capital under £23,250, the local authority calculates how much you and they should pay towards your care home fees. They allocate a '*personal budget*', a sum of money 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. 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 them, 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 following a hospital stay
- maximise your potential for further recovery and prevent you moving into permanent residential care before you really need to
- 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 a period of up to six weeks or less.

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 on a short or longer term basis.

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 are capable of doing for yourself. The goal is for you to regain as much independence as possible.

Staff discuss and agree with you what they believe you could achieve over a number of days or 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

When your initial period of intermediate care or reablement is over, 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 carry 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 in section 8.3.1.

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

8.2 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 stay in hospital. 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. It may be arranged by the hospital and delivered by a local agency such as Age UK or the Red Cross.

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). Care agency inspection reports are available on the CQC website.

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

8.3 NHS services

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 that require 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. However if there is a need for respite care, NHS and social services must agree where responsibility lies. If it is with social services, you may be asked to contribute towards the cost.

Rehabilitation and recovery services

Rehabilitation services aim to promote your recovery and maximise your independence if, for example, you had 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. This includes physiotherapists, occupational therapists (OT) or speech therapists. Speech therapists can help with both speech and swallowing difficulties.

Following a heart attack, staff should tell you about local rehabilitation services and encourage you to attend. Following a stroke, you should work with your care team to set goals you would like to achieve on leaving hospital and identify support you will need to reach them.

Rehabilitation is similar 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 you should 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. They offer course members an opportunity to learn from and support each other. Your consultant, specialist nurse, GP or NHS Choices website may have information about local courses.

8.3.1 NHS Continuing healthcare

NHS continuing healthcare (NHS CHC) is a package of care funded solely by the NHS, when it is shown that 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.

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 of your physical and mental health needs and enable you and/or your representative to play an active part. A multidisciplinary team (MDT) then uses assessment information to complete a second tool – the '*decision support tool*' which informs their recommendation about your eligibility.

You should be told how to lodge an appeal if you disagree with the decision following a full assessment.

There is a '*fast-track tool*' staff can 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*.

8.4 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 later on, 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. You are referred by your GP for 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.

8.5 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 to meet your needs.

If staff propose you move permanently to a nursing home on discharge, they should consider whether you might be eligible for NHS CHC eligibility, where necessary completing the '*checklist tool*', before deciding your need for NHS-funded nursing care. The latter is a payment the NHS makes to nursing homes for care provided by registered nurses employed by the home.

If staff propose you move permanently to a nursing home on discharge, they should consider your NHS CHC eligibility, if necessary completing the '*checklist tool*', before deciding your need for NHS-funded nursing care. The latter is a payment the NHS makes to nursing homes for care provided by registered nurses employed by the home.

If your local authority is to help fund your care home, they 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. You cannot pay the top up yourself; it must be a third party such as a family member or friend.

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. Check the terms and conditions on 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 for financial support.

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

8.6 Waiting for your chosen option to be available

There will be a hospital policy for cases where you are medically ready for discharge but are waiting for assessments to be finished or funding agreements to be reached; if there is no intermediate care or reablement available; no vacancy with your chosen care agency or at 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 for you to consider that meets your assessed needs. This should involve carrying out a risk assessment, including any impact on your carer. The discharge coordinator should explain your options, if there is to be a charge and discuss any concerns.

8.7 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 are likely to 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* and 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, your care and support plan must be kept under review. You usually have a light touch review six to eight weeks after a package begins and then not longer than 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

All patients over the age of 16 who have attended A&E or stayed overnight on a ward must be asked 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?'*

You should be asked to reply within 48 hours of discharge and to 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 the 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, approach the hospital Patient Advice and Liaison Service (PALS) and ask if they can intervene on your behalf. If this does not produce the desired result, you can make a formal NHS complaint. Ask PALS for contact details of the local NHS complaints advocacy service. This is a free 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 both 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.

The Regulations do not apply to the following types of care:

- mental health care where the person primarily responsible for your care is a consultant psychiatrist
 - palliative care (see section 8.4)
 - intermediate care (see section 8.1)
 - 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 0345 605 6055

Disability Living Allowance

Telephone 0345 605 6055 if you were born on or before 8 April 1948

Telephone 0345 712 3456 if you were born after 8 April 1948

Personal Independence Payment

Telephone 0345 850 3322

EAC FirstStop Advice

www.firststopcareadvice.org.uk

Telephone helpline 0800 377 7070

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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