

Factsheet 37

Hospital discharge

August 2019

About this factsheet

This factsheet explains what you should expect from staff planning for your discharge from hospital following NHS treatment in England. Your hospital stay should be no longer than medically necessary and you should be able to access 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 help you might need 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 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 NHS-funded treatment in England. The focus is on how staff should manage your discharge following an emergency admission. Planned NHS-funded treatment is generally provided in an NHS hospital but may be provided in a private hospital.

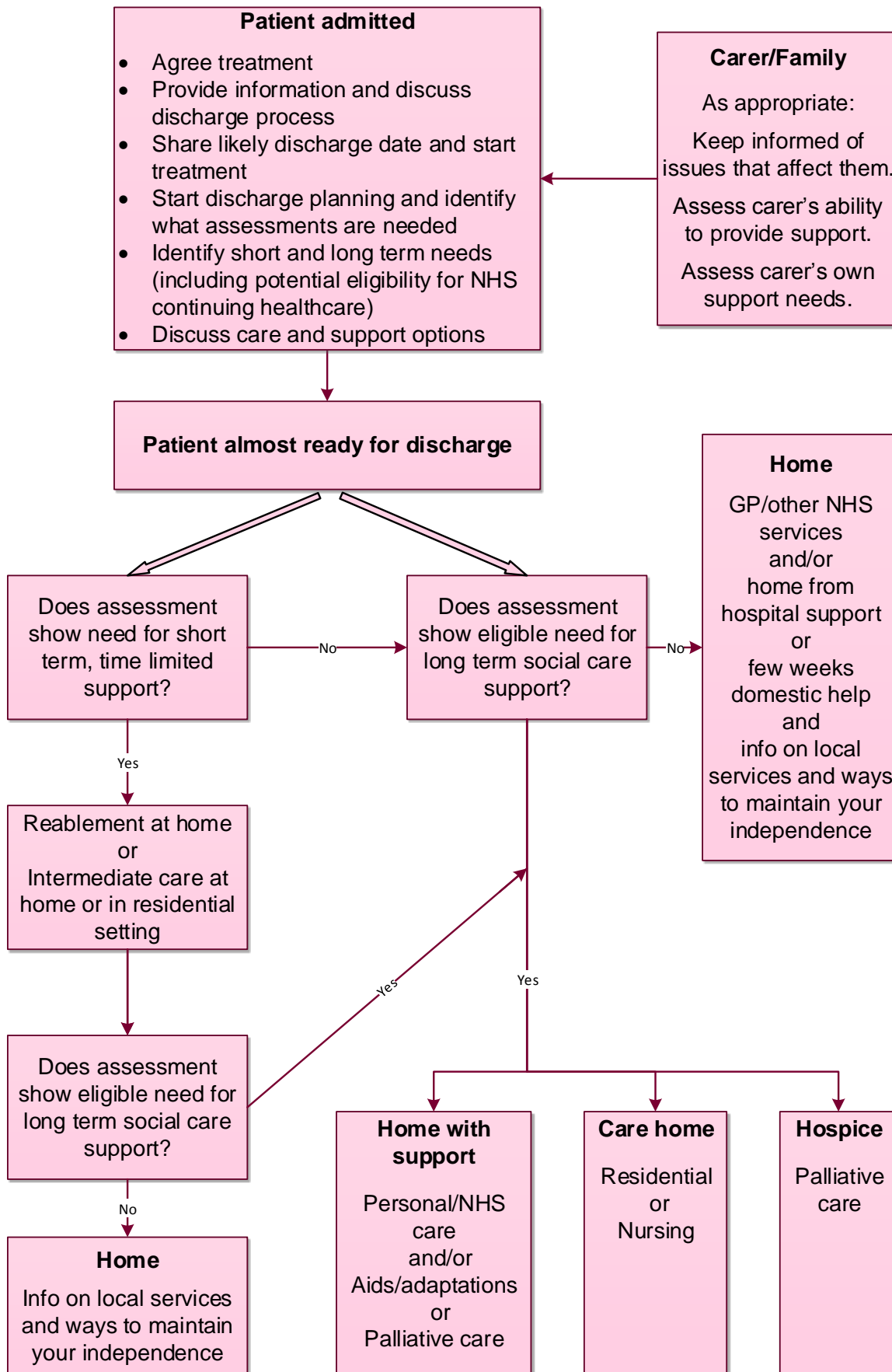
2 Hospital discharge – key steps

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 long term needs, if your discharge is likely to be complex.
- 5 Consider if you might be eligible for NHS continuing healthcare.
- 6 If the assessment finds you have eligible social care needs, staff should 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 a financial assessment to calculate how much you must pay towards the cost of your care, if arranged by the local authority.
- 8 If not eligible for local authority funding, 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.
- 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 to a hospital consultant results in an outpatient appointment. The referral letter should explain, and the hospital should respond to, any communication needs you have. Appointment letters and information can be sent in large print, easy read, Braille or audio.

To ensure you can take an active part in discussions at your appointment, the hospital may need to arrange a British Sign Language interpreter, lip reader, deaf blind interpreter or advocate. If English is not your first or preferred language, the hospital can invite a registered interpreter to assist you.

The consultant may want to arrange further tests to reach a diagnosis before discussing treatment options with you. Agreeing to have treatment may mean a planned hospital admission is necessary.

Questions to ask the consultant 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? Under the *Equality Act 2010*, it is unlawful for doctors, without good or 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).
- What are the benefits, side effects, risks and success rates of each treatment being proposed? 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?
- If I need further tests or treatment, will I be an inpatient or day patient?
- If I am an inpatient, what is the likely length of my stay?
- Is there anything I can do before my treatment, while I am in hospital, and when I go home to support my recovery?
- How long before I know if the treatment is working or has worked?
- When will I be able to go about life as usual? Will I need help at home? If so, what type of help and for how long? Tell staff about your home environment and any help you currently receive. The more they know, the easier it is to ensure you have the right support on leaving hospital.
- Do you have written information about my health condition, treatment or national or local support groups? What websites would you recommend?

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
- 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
- be moved to a special ward for tests or monitoring to help decide whether to discharge or admit you. This ward 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. This contains up-to-date information about your medicines, those you react badly to and any allergies. You may want your GP to add information about your health and preferences for future care, to help doctors seeing you in an emergency situation.

If you are unable to communicate with staff, access to your SCR helps a doctor understand your health history, make a diagnosis and decide how to treat you. 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. Whereas staff are likely to focus on the main reason for your arrival at hospital, it is important they enquire about your health more broadly. It may have a bearing on this admission and by identifying associated issues now, they may be able to initiate treatment and prevent problems in the future.

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 those 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, race, gender, religion or belief, sexual orientation, gender reassignment 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 National Institute for Health and Care Excellence (NICE) 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 or find menu choices unsuitable because of 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 can:

- ask family members or others important to you, if you usually need help to make decisions;
- check if you have made a health and care decisions Lasting Power of Attorney (LPA); or
- check if the Court of Protection has appointed a Welfare Deputy to act on your behalf.

They should also ask if you have made an advance decision to refuse treatment.

Best interest decisions

If no one has been appointed 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. They 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. While you have mental capacity, 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.

For more information about attorneys, see 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.

If you lack capacity to make decisions about treatment and care and have appointed a health and care attorney, staff should fully involve them, so they can make decisions on your behalf.

If you have not appointed anyone to act as your attorney, staff should give your informal carer information to enable 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, for example, whether it should be a residential or nursing home.

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 can include letting staff know what name you like to be called, any 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 and to read a guide indicating what implementation of this scheme might mean for patients and carers, 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 Service Centre 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 you are going to pay for planned treatment in a private hospital or are arranging it 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 the 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. There may be a 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. This should be 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 for 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 if that is where you live, as soon as they know it, review it regularly and share any changes with you and relevant others. 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 support, over 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 support, staff must re-assess your needs to see if you need further short or long term support.

5.2 Considering eligibility for NHS continuing healthcare

Due to the nature, complexity, intensity or unpredictability of your needs, staff may want to consider your eligibility for NHS continuing healthcare (NHS CHC). They should undertake this at the right time and location for you. It can be difficult to accurately reflect your on-going needs on a busy hospital ward and you may have the potential to recover further, with additional support. If practicable and in your best interests, staff may propose an assessment outside a hospital setting. They may consider '*fast track*' if your condition is deteriorating rapidly and you may be reaching the end of your life. See section 8.5 for more information.

5.3 Assessing need for long-term social care 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. Social workers are usually members of the discharge team in general hospitals.

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 when assessing your needs and 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 you do not, to establish your underlying eligibility for care and support.

The aim is to identify any NHS services you need on discharge, and to 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, engaging in 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 your eligibility for 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 and 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 **discharge to assess (D2A)** for some patients. This can minimise time spent in hospital and help maintain mobility and confidence, which you can lose 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 provide *necessary* support when you are discharged, they have a right to an assessment, and to have their own support plan if found eligible.

If not eligible, staff should explain why and give your carer information about organisations that can help them. If staff cannot complete the carer assessment or review their current support plan before your discharge, this should take place as soon as possible post discharge. Your carer should get the support they are eligible for, for example to have a break from caring.

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 explains the outcome to you, your carer or family where appropriate, and discusses the options for meeting your needs and whose responsibility this is. Any NHS services you need, such as those explained in section 8.2, are free of charge and arranged via the hospital or your GP.

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 more information, see section 7.

Next, staff must 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 have a partner or informal carer, staff should ask them if they are able and willing to start, or to continue providing care or take on additional tasks. This should not be assumed. Staff should identify and arrange any training to help them in their role.

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 your care needs getting worse.

When the NHS has a duty to meet your needs

This is described in section 8.5 about NHS continuing healthcare.

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 more 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 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 for you.

Note

A local authority must arrange home care without an administration fee, or a care home place for a *self-funder*, if they do not have mental capacity to make their own arrangements 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 provide a written record of their decision, with reasons, and provide information and advice to help you meet your needs. This might include details of local care agencies, or voluntary organisations offering support such as a local Age UK. You can ask the local authority to reconsider its decision, or challenge it, if you disagree with it.

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?
- are 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 a care home, has the manager been informed of the date and likely time of your arrival? Do you need to take a copy of your discharge plan, including medication needs, with you, or have staff arranged to forward copies to the care home 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 you are now taking
- 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, see the factsheets noted below.

7.1 Paying for care at home

The local authority carry 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 still 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 they must pay towards your fees. You are allocated 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 are a *self-funder* and must arrange and pay for your care home place yourself, unless you lack mental 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 this amount, to allow time for them 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. Not all patients have the potential to benefit from such support. If your needs suggest a permanent place in a care home is a serious possibility, it is particularly important for staff to consider if you could benefit from this type of support.

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 CHC, or
- help you avoid going into hospital unnecessarily.

If staff believe you have potential to achieve jointly agreed goals, local authorities they must not charge for services they provide to help you do this, for up to and including six weeks. You may be given aids and equipment to help you. They can use their discretion to offer this support free of charge for longer than six weeks, where there are clear benefits. This might be if you have recently become visually impaired or have dementia and staff believe there is potential for you 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 explain to you, and where appropriate your family, what they hope you could achieve within an agreed time frame and discuss the care and support plan they propose to help you achieve agreed goals. Depending on your needs, this can involve a range of professionals such as nurses, physiotherapists and help with personal care.

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

Throughout and at the end of your agreed period of intermediate care or reablement, staff should review progress, see if you have reached your goals and ask if more could be achieved if they allow extra time.

Once it is agreed no further improvement is likely, you and 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 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 8.5.

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. It 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 aims to promote your recovery and maximise your independence, for example, after a heart attack or stroke. Services begin while you are in hospital and can continue for weeks or months after.

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. Rehabilitation has a similar purpose to intermediate care but it starts in hospital, is delivered by NHS staff or funded by the NHS, and is not time limited.

After a heart attack, staff should tell you about local rehabilitation services and encourage you to attend. After a stroke, you should work with staff to set goals you would like to achieve when you leave hospital and identify the support you need to reach them.

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 practice staff. There is information about many health conditions on the NHS website.

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

NHS-funded nursing care

NHS-funded nursing care (NHS FNC) is a payment made to a nursing home (care home registered to provide nursing care) as a contribution towards care provided by nurses employed by the home. The NHS pays it on behalf of self-funding and local authority supported residents. See factsheet 20, *NHS continuing healthcare and NHS-funded nursing care*.

8.3 Going home

With a care package

This may be arranged and funded by you or the local authority.

Help at home with domestic tasks

You may only need 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 a private agency.

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, sort out post and paperwork, and help with light housework and shopping. Staff aim to keep in touch, have a chat and check you are managing on your own. The hospital may arrange it and ask agencies, including Age UK or the Red Cross, to deliver it. These agencies may also deliver their own free or charged for service.

Help from private care agencies

Private care agencies help with personal care and domestic tasks 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 you pay for your own care or receive a direct payment from social services, you may decide to buy services from an agency. Your local authority has details of agencies. UK Home Care Association has members who provide live-in carers.

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
- information and advice
- non-residential respite care.

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.

Local authority support

If the 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*.

Self-funding a care home place

As a *self-funder*, you have a free choice of home but when considering fees, be mindful of how long your money will last before you need to apply for local authority help with fees, as raised 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.

If you are to move into a *nursing home*, ask homes you visit to explain how their fee structure takes account of the NHS FNC payment, described in section 8.2. Check how they address this in their contract and terms and conditions, including the effect of NHS FNC rate changes.

If proposing you move permanently to a *nursing home*, staff should consider if you might be eligible for NHS CHC. If unsure, they should complete the '*checklist tool*', before deciding your need for NHS FNC.

8.5 NHS continuing healthcare

NHS continuing healthcare (NHS CHC) is a package of care funded solely by the NHS, if your need for care is primarily a health need. Staff must follow the 2018 '*National Framework for NHS CHC and NHS-funded nursing care*' to decide eligibility. If eligible, you can receive NHS CHC at home, in a care home, hospice or other suitable location.

If staff believe you may be eligible or are unsure, 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, staff 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 that looks at your physical and mental health needs in more detail, and enable involvement of you and your family. A multidisciplinary team 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*' 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*.

8.6 Waiting for assessments or your chosen option

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

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

8.7 Palliative care support

You can be offered palliative care services when diagnosed with a progressive illness that cannot be cured. Originally it was only offered to people with cancer but is now available in many parts of the country 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 or be on hand, as and when you need them. This might be emotional support for you and your family to help you at the time of diagnosis and as your illness progresses, 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, clinical and non-clinically trained hospice staff or '*hospice at home*' teams, Marie Curie nurses and staff supported by Macmillan.

You may want to discuss with health professionals caring for you, how you would like to be cared for as you approach the end of your life. You can involve your family or friends if you want to. This is known as '*advance care planning*' and means all caring for you are aware of your wishes and can plan accordingly.

Speak to your consultant or GP about local availability of, and referral process for, end of life care services. For general information search '*palliative care*' or '*end of life care*' on the NHS website.

If you have a rapidly deteriorating condition that may be entering a terminal phase, ask hospital staff if you should be '*fast tracked*' onto NHS CHC, as per section 8.5.

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, use the EAC online HOOP tool, or see Age UK guides *Housing options* and *Adapting your home*, factsheet 2, *Buying retirement housing* and factsheet 64, *Specialist housing for older people*.

9 Reviewing your care and support needs

If the local authority arranges or funds your care package, you should know who to contact with any concerns and your care and support plan should be kept 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 care and support arranged through 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. They must agree which of them will take the lead and 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 Service Centre

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.

Hospice UK

www.hospiceuk.org

The national voice of hospice care in the UK, working with member organisations to support their work and promote delivery of high quality care. They have a web-based postcode hospice finder.

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 website

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.

Royal Voluntary Service

www.royalvoluntaryservice.org.uk/

Telephone 0330 555 0310

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 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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