

Factsheet 37

Hospital discharge and recovery

November 2023

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 following discharge.

You may like to read other Age UK factsheets about the 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 advice. 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

If your hospital admission is *planned*, your stay and abilities on leaving are more predictable. *Planned* NHS-funded treatment is generally provided in an NHS hospital but may be provided in a private hospital.

An *emergency admission* brings more uncertainty, but staff should follow steps to ensure your stay is no longer than necessary, and you receive the right care and support, once a doctor says you are ready to leave.

2 Hospital discharge key steps

Staff should:

- 1 Explain and provide information about the discharge process in a format you can understand and engage with, soon after admission.
- **2** Start discharge planning on admission or before for planned procedures. Ask about and take account of your home circumstances.
- **3** Ask who you would like to be involved or informed of discussions and decisions about your discharge.
- 4 Review your needs regularly and share the criteria the doctor will use to decide you are ready to be discharged, where they think you are likely to be discharged to, and when.
- 5 If you have no formal care needs, facilitate your discharge home.
- **6** Ensure that required medication and essential equipment is provided at the point of discharge, and transport arranged.
- 7 If likely to need ongoing support, appoint a case manager to arrange where you are discharged to. There should also be settle-in support, if needed when you arrive.
- 8 If you could benefit from support to recover further, arrange an assessment to identify and agree a short-term recovery and support plan with you. Review progress regularly, followed by consideration of your long-term care needs.
- **9** If your partner or carer will provide ongoing care and support on discharge, explain their right to a separate carer s assessment.
- **10** Provide the contact details of your discharge team on discharge and advise you to contact them with any concerns.
 - The flow chart on the following page summarises this journey.

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 as \$\frac{1}{3} \frac{1}{3} \fr

The hospital must ensure you can take an active part in discussions at your appointment and may need to amy ange 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 hospital may ask you to consider a telephone or video appointment.

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Questions to ask the consultant at an outpatient appointment

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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 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. Ambulance services and EDs can refer to *urgent community response teams* who can arrange short term health and social care support at short notice (within two hours if required). 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

If registered with a GP, you have a Summary Care Record (SCR), unless you choose not to have one. This contains up-to-date information about your medicines, those you react badly to and any allergies. You can ask your GP to add information about your health and preferences for future care, to help doctors treating you in an emergency situation.

If you cannot communicate with staff, having access to your SCR helps a doctor understand your health history,

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, disability, gender reassignment, marriage and civil partnership, race, religion or belief, sex, or sexual orientation

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, involving your family and carers as appropriate

be given the chance to managriate

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 registered a Lasting Power of Attorney (LPA) for health and care decisions, or

check if the Court of Protection has appointed a Welfare Deputy to act on your behalf.

They should ask if you have made an advance decision to refuse treatment. For further information, see section 2 of factsheet 72, *Advance decisions, advance statements and living wills.*

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 about your treatment or ongoing care, 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.

best interests

your behalf involving serious medical treatment, a permanent change of residence, or temporary one lasting more than eight weeks, or a hospital placement likely to be longer than 28 days, and you do not have family or friends other than paid staff to consult about the decision, staff should

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 best interests ial 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 under an LPA and make decisions on your behalf if, at some time in the future, you can no longer make them for yourself.

For information about attorneys, see factsheet 22, *Arranging for someone to make decisions on your behalf.*

Anyone requiring formal care and support should receive an initial safety and welfare check on day of discharge to ensure care needs are met.

If your needs are too great to return to your own home, you may be discharged to a residential setting such as a community hospital or care home. As options for residential care can be limited, discuss any concerns you have with staff involved in arranging your discharge. Support, over and above what you were receiving prior to your hospital stay, may be free of charge

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

This includes reablement and is designed to achieve one or more of the following:

support timely discharge from hospital and help you be as independent as possible, or

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 financial assessment to see if you must pay towards future care costs.

If you are offered intermediate care prior to starting the process to decide NHS CHC eligibility and you reach a point where no further improvement is likely, staff must initiate the procedure described in section 8. For more information, see factsheet 76, *Intermediate care and reablement*.

7.2 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, community-based staff such as district nurses, continence nurses, dietitians, and community mental health nurses. For more information, see factsheet 44, NHS Services.

Rehabilitation

Rehabilitation aims to promote your recovery and maximise your independence, for example, after a heart attack or stroke. It begins while

7.4 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.

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.*

7.5 Palliative and end of life care

Consideration must be given if you have palliative care needs, or are approaching the end of your life, during the hospital discharge process.

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 as necessary, to control and manage pain and other physical symptoms.

End of life care is provided if you are thought to be in the last year of your life. This includes if you are generally frail with multiple conditions.

The provision of specialist palliative and end of life care services may include support to maximise your independence or focus on meeting other personal goals. Speak to your consultant or GP about the local availability and referral process for, palliative and end of life care services. For general information, palliative care end of life care on the NHS website.

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 to. This is known as advance care planning everyone caring for you is aware of your wishes and can plan accordingly.

8 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 (CHC). This is usually carried out after you are discharged from hospital.

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 *'National Framework for NHS CHC and NHS-funded nursing care'* to decide eligibility. If eligible, you can receive CHC at home, in a care home, hospice or other suitable location.

The first step i checklist tool' with your involvement, if you are happy to do so. This aims to identify if you need a full assessment to decide eligibility.

If completing 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 are eligible. Staff should tell you the checklist result, record it in your notes, and seek your consent to participate in the full assessment looking at your physical and mental health needs in more detail

9 Assessing need for long-term social care

Staff are not required to conduct assessments for long-term social care support in an acute hospital setting.

9.1 Social care needs assessment

The assessment should involve you and family or friends who

9.1.4 When your local authority has a duty to meet your needs

If you have eligible needs, there is a financial assessment to decide how much, if anything, you must pay towards the costs of providing care services.

A care and support plan is drawn up 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, wellbeing and 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 made to move to a care home if you do not consent to this and you have mental capacity to make

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.

See section 5.3 of factsheet 41, *How to get care and support*, for more on the right to request the arrangement of care services.

9.1.6 If your needs do not meet eligibility criteria

If your needs do not meet eligibility criteria, you should be given a written record of the decision, with reasons, and 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.

10 Paying for social care

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

10.1 Paying for care at home

The local authority carries out a financial assessment

Local authority support

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 *personal budget* the overall amount the local authority considers it costs to meet your eligible needs in a care home.

The local authority 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 t third party personal budget and the actual fees.

third party

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.

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10.3 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.

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 advocacy service that aims 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 unhappy with their response and social services arranged the services, raise it with social services. If you arranged services yourself and are unhappy with their response, you can take the complaint to 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 (CQC) registers and inspects care agencies, care homes and hospitals and requires them to have a complaints procedure.

The CQC has a new duty to inspect local authorities and Integrated Care Systems, responsible for health and care services in their localities. It does not investigate individual complaints but encourages people to share good and bad experiences with them by phone, letter or *share your experience* 2 on their website.

For more 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

Health and Care Act 2022

www.legislation.gov.uk/ukpga/2022/31/contents

Hospital discharge and community support: policy and operating model

www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model/hospital-discharge-service-policy-and-operating-model

NICE 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. See www.nice.org.uk/

Quick Guide: Discharge to Assess

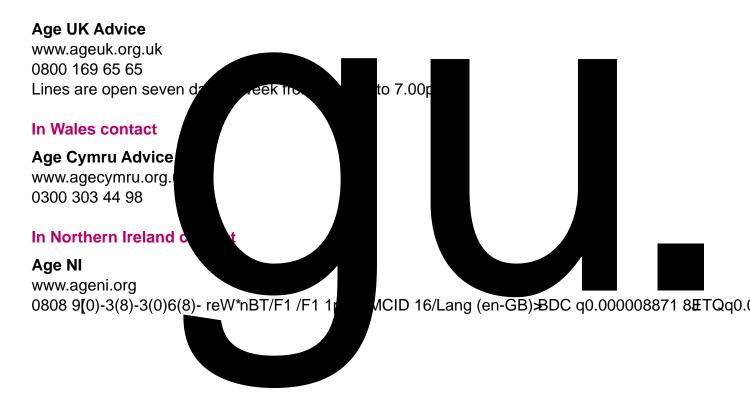
www.nhs.uk/NHSEngland/keogh-review/Documents/quick

EAC FirstStop Advice

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

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.



Our publications are available in large print and audio formats

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The evidence sources used to create this factsheet are available on request. Contact resources @ageuk.org.uk

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