

Factsheet 37

Hospital discharge and recovery

November 2025

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. You should be able to access ongoing care and support in the most appropriate setting following discharge.

You may like to read other Age UK factsheets about the care and support available from your local authority social services department, such as funding for care at home or in a care home, and NHS Continuing Healthcare.

The information in this factsheet is correct for the period November 2025 until October 2026. However, rules and guidance can sometime change during the year.

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 Recent developments

The patient safety initiative *Martha's rule* is available in all acute hospitals in England. Martha's rule recognises that those people who know you best may be the first to notice changes that could be an early sign of deterioration in your condition. See section 5.4.

2 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. If so, the hospital discharge guidance is still applicable.

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.

Whilst this factsheet explains national guidelines for England, but discharge processes can vary between different local areas.

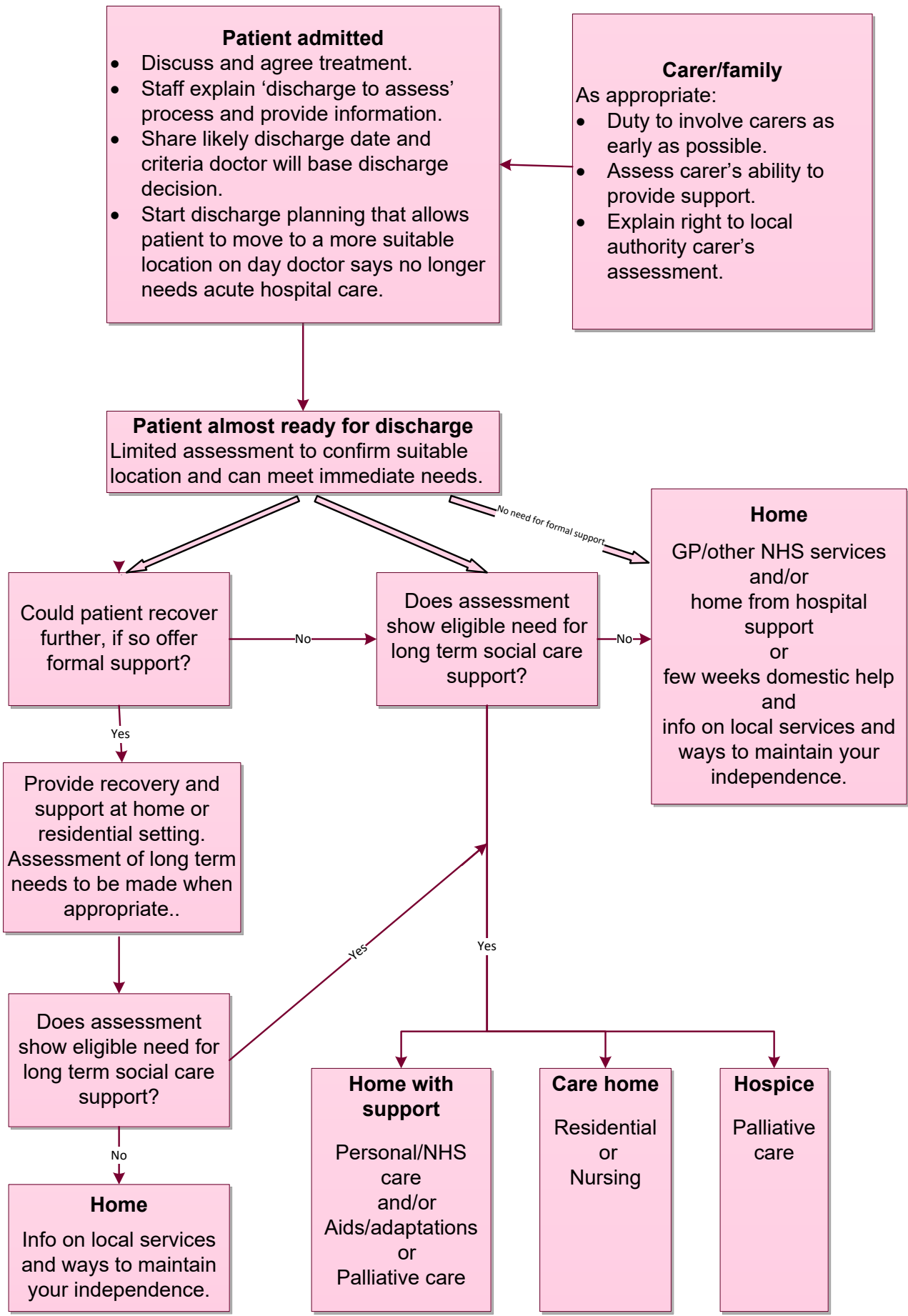
3 Hospital discharge – key steps

When you are preparing for discharge from hospital, the 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 current 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 you need ongoing support, referral to the care transfer hub and a case manager appointed to arrange discharge and any immediate support.
- 8 Assessment arranged 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 details of who to contact after discharge with any concerns.

The flow chart on the following page summarises this journey.

Hospital discharge pathway



4 Going into hospital

4.1 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.

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

The consultant may want to arrange further tests to reach a diagnosis before discussing treatment options with you.

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 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, how long might I need to wait for treatment to begin and 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?

4.2 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
- able to stay at, or return, home. Ambulance services and EDs can refer you to *urgent community response teams* who 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
- 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 you are 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, 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 an 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. Whilst 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 when deciding your needs once discharged.

5 Your hospital stay

5.1 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 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 dietary and weight issues when arranging your discharge.

5.2 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 Age UK 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 mental 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 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.

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, 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 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 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 Age UK factsheet 22, *Arranging for someone to make decisions on your behalf*.

5.3 Involving your family or carer

NHS hospitals and foundation trusts have a duty to involve you and where appropriate, unpaid carers and family members in hospital discharge planning, as soon as feasible, if it is likely you will need care and support upon discharge.

Whilst your consent is required to share details about your care and treatment in hospital, they have a duty to involve your carers to determine if they are willing and able to provide the care they intend to once you are discharged. A carer is as someone who provides or intends to provide care for you, not employed carers or voluntary workers.

If you lack capacity to make decisions about treatment and care and have registered a health and care attorney, staff should fully involve them, to help make appropriate decisions on your behalf.

If you have not registered an attorney, staff must make a 'best interests' decision on your behalf and should consult your family or carer before doing this. Staff should give your carer information to enable them to safely carry out tasks they agree to undertake.

If family members are responsible for making arrangements to meet your ongoing care needs, staff should provide information to them, so they understand the type of care to look for, for example, whether you need a residential or nursing home.

5.4 Martha's rule

Operating in all acute hospitals in England, *Martha's rule* recognises that those who know you best may be the first to notice changes that could be an early sign of deterioration in your condition.

If there are worries that your condition is worsening or not being managed effectively, Martha's rule gives you, your family, carers and staff the right to raise these concerns and assurance that concerns will be listened to and acted upon. After raising concerns, if you are not satisfied that they are being taken seriously, you can call a dedicated number to request a rapid review from a specialist critical care team.

5.5 Supporting a patient living with dementia

Time spent in an emergency department or hospital ward can be frightening and confusing if you have memory problems or dementia. If you have dementia, it is helpful for your family to share information with staff about this affects you. This aids staff to 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 family/carer can record this information in a leaflet '*This is me*' available from the Alzheimer's Society at www.alzheimers.org.uk/get-support/publications-factsheets/this-is-me

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 working with them, throughout a hospital stay and when planning discharge, benefits the patient and hospital staff. For more information, see www.johnscampaign.org.uk

5.6 Benefits while in hospital

If you receive Attendance Allowance (AA), Disability Living Allowance (DLA) or Personal Independence Payment (PIP), tell the Disability Service Centre when you go into and come home from hospital.

Payment is suspended once you have been in hospital for more than 28 days, including the day of admission. If you transfer from hospital to a care home or community hospital for free short-term support, this counts towards the 28-day limit.

Payment of AA, DLA or PIP should resume on leaving hospital or at the end of free short-term support, unless you start receiving local authority funding for a permanent place 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. If someone receives CA for looking after you and you go into hospital, their CA stops when your AA, DLA or PIP is suspended.

If you receive Pension Credit (PC) Guarantee Credit, suspension of these benefits can affect the amount of PC you receive. If your PC award stops, you may not be able to reclaim it if you are a couple and one of you is under State Pension age. See section 2.2 of Age UK factsheet 48, *Pension Credit* for more information.

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

Housing Benefit can continue to be paid for up to 52 weeks if you are in hospital. See Age UK factsheet 17, *Housing Benefit* for more information.

Contact your local Age UK with queries about benefits while in hospital.

5.7 If your treatment is not funded by the NHS

If you 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 what post-discharge support the hospital provides and whether they provide aids for use in the short term, to help with mobility or ensure your safety, if you need them.

You have a right to an assessment by your local authority where it appears you may have needs for care and support. Social services staff are not based in private hospitals, so contact your local authority social services department once you have a confirmed admission date. Explain the kind of support the consultant says you may need and for how long, which could indicate if your needs are likely to meet eligibility criteria.

Social services have a duty to meet your needs if they meet eligibility criteria. You may have to pay towards the cost of services they arrange, see section 12. 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 voluntary organisations that could help. There may be a charge for this type of support.

6 Arranging discharge

Hospital discharge planning should begin on admission. This gives you, your family and carers time to explore available options to best meet your needs on discharge. Using set criteria your healthcare team will regularly review whether you are ready for discharge.

Once the team agree that your discharge is **safe and appropriate**, staff should discuss options for meeting any immediate needs you have on leaving an acute setting. Only in exceptional circumstances are your long-term needs identified at the time of discharge. Long-term needs should be assessed after a period of recovery.

6.1 Discharge to assess

The process known as '*discharge to assess*' or '*home first*' recognises people have different needs once they no longer need care in an acute hospital, as such, the NHS and local authority work together.

Staying longer than necessary is not good for your recovery or wellbeing. Staff are asked to arrange discharge on the day the doctor agrees you no longer need hospital care. **You cannot stay in hospital if you choose not to accept the care offered to you on discharge.**

See overleaf for descriptions of the different hospital discharge pathways.

The discharge to assess (D2A) process identifies four discharge pathways for patients:

- 0 - need minimal help on discharge
- 1 - would benefit from short term support to recover further at home or usual place of residence, before assessing your long-term care needs
- 2 - would benefit from short term support to recover further in a residential setting, before assessing your long-term needs
- 3 - unlikely to benefit from short term support and need ongoing nursing care, most probably in a nursing home.

D2A is underpinned by the principles of home first, but how it is implemented can vary between hospitals. Ask the hospital discharge team about local arrangements.

If it appears that you will need support from social care services as part of your discharge and recovery, hospital staff should inform the relevant local authority of this need as early as possible.

Minimal support on discharge – pathway 0

Ward staff manage discharge of patients needing only minimal help or returning to a pre-existing package of care at the same level as pre-admission, for example with transport home or to switch on heating.

They can provide information on organisations who can help with tasks like shopping for a few weeks. See section 9.3 for more information.

Support to recover further at home or your usual place of residence – pathway 1

You may have potential for further recovery when your need for hospital care finishes, before an assessment of your long-term needs is made.

If so, staff should discuss with you what this might mean for you and appoint a case manager, based within the local care transfer hub (a group of professionals from different disciplines responsible for co-ordinating formal care following hospital discharge).

The case manager arranges your discharge and any immediate or settle-in support needed. If family or friends intend to provide care, staff must check they are willing and able to do so and discuss option of a carers assessment if needed.

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

Support to recover further in a residential setting – pathway 2

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 for a limited time.

Under D2A, you may be offered a period of intermediate care to support your recovery either at home or in a residential setting, which should be provided free of charge for up to six weeks, see section 9.

Unlikely to benefit from further support – pathway 3

Ward staff will discuss your long-term needs with you and your family/carers as appropriate. They should appoint a case manager to arrange discharge to a care home and a full needs assessment, so you can review your options and move to your long-term care home as soon as possible.

Check with the hospital discharge team how any care you need will be funded and for how long upon discharge.

Trusted assessors

Trusted assessor schemes are used in many areas to promote safe and timely hospital discharges and reduce delays.

Schemes use *Trusted assessors*, who are qualified professionals, to carry out holistic health and social care assessments and develop care plans to meet identified needs, on behalf of social care providers.

7 Virtual wards and hospital at home services

Virtual wards offer treatment and monitoring in your usual place of residence, including a care home, if you would otherwise be admitted to hospital. They can be used to facilitate early discharge.

Virtual wards have been developed for various conditions such as respiratory problems, heart failure, and acute exacerbation of a frailty related condition. They rely on different technologies with minimal face to face contact. However, a blend of technology and face to face support may also be an option and is often referred to as '*hospital at home*'.

Discharge from a virtual ward or hospital at home service follows the same process as a discharge from a hospital admission. Therefore, you may go through the discharge to assess process outlined in section 6, if you have ongoing care and support needs.

8 Discharge from mental health inpatient settings

If you are an inpatient in a mental health setting, you should be discharged once you are clinically ready for discharge, meaning that no further assessments, interventions or treatments are required in a hospital setting. You and your carer, if appropriate, should be involved in your discharge planning and there should be a clear plan for your ongoing care, which should be in place prior to discharge.

If detained under the *Mental Health Act 1983*, how your care is planned and arranged on discharge may differ depending on which section you have been detained under.

For example, if you are detained on sections 3, 37, 47, 48 or 45A, you are entitled to free 'aftercare' arranged under section 117 of the Act. For more information, see the MIND website www.mind.org.uk/information-support/legal-rights/leaving-hospital/section-117-aftercare/

9 Further support options

9.1 Intermediate care and reablement to maximise recovery

This type of support is likely to be offered if it is thought you would benefit from it. Intermediate care, which includes reablement, offers a period of time-limited support and aims to help rebuild your confidence and maximise your ability to live independently.

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 and reablement are designed to achieve one or more of the following outcomes:

- 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, this support is free for **up to** six weeks. You may be given aids and equipment to help you.

They have 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 should work with you, and where appropriate your family, to develop an individual rehabilitation plan and agree a time frame to 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 a recovery plan with you. 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 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 10.

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

9.2 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 Age UK 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 you are in hospital and can continue for weeks or months.

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.

You may receive NHS support, as an individual or in a group, from a range of health professionals, including physiotherapists, occupational therapists or speech and language therapists. Speech and language therapists can help with both speech and swallowing difficulties.

After a heart attack, staff should tell you about local rehabilitation services and encourage you to attend. 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.

Medication

If your medication has changed following a hospital stay, you may be offered a referral to your community pharmacy discharge medicines service. If so, the pharmacist will be informed of any changes that have been made, so they can support you by explaining the purpose of each medication, any possible side effects and how to safely take 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.

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 Age UK factsheet 20, *NHS Continuing Healthcare and NHS-funded nursing care*.

9.3 Going home

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. Someone might help you settle at 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 services.

Help from private care agencies

Private care agencies can 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. The Homecare Association has members who provide live-in carers.

With a care package

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

Help from voluntary sector organisations

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

- meals-on-wheels
- lunch clubs and day centres
- home visiting and telephone befriending
- handyman schemes – help with minor jobs around the home
- information and advice
- non-residential respite care.

9.4 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*, and Age UK factsheet 2, *Buying retirement housing* and factsheet 64, *Specialist housing for older people*.

9.5 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. Search '*palliative care*' or '*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*' and means everyone caring for you is aware of your wishes and can plan accordingly.

You can receive support while living in your own home, care home, hospice or hospital. Community palliative care teams will co-ordinate discharges to your home or to a hospice if you are identified as being in the last days or weeks of your life.

If you have a rapidly deteriorating condition that may be entering a terminal phase, ask hospital staff if you should be considered for '*fast track*' NHS CHC, as noted in section 10.

9.6 Moving to a care home

Because of the level of your needs, a move to a residential home or a nursing home may be agreed as the only safe and effective option. The Age UK *Care home checklist* has issues to think about and questions to ask when choosing a care home.

10 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). 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 is to complete the Framework's '*checklist tool*' with your involvement, if you are happy to do so. For most people, this takes place after discharge from hospital, following a period of recovery, and aims to identify if you need a full assessment to decide eligibility.

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. An assessment can be carried out without your consent.

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. If eligible, staff agree a care plan, review it after three months, then at least annually.

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.

If eligible for CHC, the NHS covers the whole cost of care and support services provided to meet your eligible needs. If your needs fall below this threshold, you can ask for a local authority care needs assessment, regardless of your financial situation.

See Age UK factsheet 20, *NHS continuing healthcare and NHS-funded nursing care*, for more information.

Fast track

There is a separate ‘**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 CHC.

The NHS should act immediately on this recommendation, so necessary care and support is in place, ideally within 48 hours.

11 Assessing need for long-term social care

Assessments for long-term social care support should not take place in an acute hospital setting. An assessment should take place when you have reached a point of recovery and stability. The assessment is carried out by the social services department of the local authority.

11.1.1 Social care needs assessment

The assessment should involve you and any family or friends who act as your carer. The aim is to find out what care and support you think you need, whether you can do certain activities, and may also identify any NHS services you need.

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 activities that contribute to your wellbeing, like keeping in touch with family and friends and using local transport and services.

If you have a carer, you must be assessed as if you do not, to establish your actual need for care and support.

11.1.2 Eligibility for care and support

In assessing eligibility, your ability to complete daily living activities is described as '**achieving desired outcomes**'. The authority 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 physical or mental impairment or illness. You must be unable to achieve at least two '**desired outcomes**' in your day-to-day life and this must have a significant impact on your wellbeing. For more information, see Age UK factsheet 41, *How to get care and support*.

11.1.3 Assess your carer's needs and eligibility for support

If you receive help from a partner or informal carer or they want to provide *necessary* support to you at home, they have a right to ask for a carer's assessment and have their own support plan if found eligible. Carers UK offers information and advice for carers.

11.1.4 Planning and arranging care

Once your needs assessment is complete, your case manager 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 in section 9.2, are free of charge and should be arranged via the hospital or your GP.

11.1.5 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 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 and take account of your wishes, wellbeing and 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 that decision. If you are advised it is the only safe and effective way to meet your needs, you can 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.

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

11.1.6 When you must make your own care arrangements

If your financial resources are above eligibility limits, the authority may not have a duty to put arrangements in place for you. You are usually expected to arrange and meet the costs of care yourself as a '*self-funder*'. You can ask them to arrange your home care package and they must agree to your request but can charge an arrangement fee on top of the costs of services. You can ask them to arrange a care home place for you but this is a discretionary decision so they may not agree.

Mental capacity - A local authority must arrange home care or a care home place without an administration fee if you are a self-funder *and* do not have mental capacity to make your own arrangements and have no one to help you.

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 how the local care system works, 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. You should be told about ways to prevent your needs getting worse.

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

11.1.7 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, which you can challenge if you disagree.

12 Paying for social care

If the local authority agree you have eligible needs for care and support, they carry out a financial assessment to decide how much you must pay towards the cost of meeting your needs. This takes account of your capital (savings, etc) and income. Capital below £14,250 is completely disregarded. If you have capital over £23,250, you are not eligible for local authority funding assistance and are a self-funder.

If you are entitled to the local authority's funding assistance, they must ensure that your weekly income does not fall below a certain level. The amount varies depending on where you receive your care and your personal circumstances.

You are allocated a '*personal budget*' which is the overall amount they consider it costs to meet your needs. This must be part of your care and support plan. You can choose to have a *direct payment* and arrange your own care, instead of asking the local authority to arrange it for you.

12.1 Paying for care at home

If you are entitled to local authority help with funding, you must be left with a level of income called the Minimum Income Guarantee (MIG). If you are single and have reached State Pension age, the MIG is £232.60 a week. If you are a member of a couple and one or both of you has reached State Pension age, your individual MIG is £177.55 a week. If you both receive care and support services from the local authority and one or both of you are over State Pension age, you should each have a MIG of £177.55 a week.

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

12.2 Paying for care in a care home

If you are eligible for local authority help with funding for a care home, they should provide a list of suitable homes to view, offering 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 and you meet other choice of accommodation criteria.

You must be left with a Personal Expenses Allowance (PEA) of at least £30.65 a week. You should not be asked to put your PEA towards the cost of meeting your eligible needs if you are a permanent or temporary care home resident. It is for your own personal use.

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 in section 7.5 of Age UK factsheet 29, *Finding, choosing and funding a care home*.

Self-funding a care home place

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 a few months before reaching this amount, to allow time for them to carry out a needs and financial assessment.

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.

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.

Moving to a nursing home

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 9.2. 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.

For more information see Age UK 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*.

12.3 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.

13 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. You can get contact details for PALS from the hospital reception or hospital website or see www.nhs.uk/service-search/other-health-services/patient-advice-and-liaison-services-pals

If contacting PALS does not produce the desired result, you can make a formal 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 NHS care and support arranged through social services (a complaint about hospital discharge may involve both), you need only make one complaint covering all issues to either the hospital or social services. The organisation receiving your complaint must contact the other one and agree which of them will take the lead and ensure you receive a single response addressing all your points.

Care Quality Commission

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 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*' on their website.

For more information, see Age UK factsheet 59, *How to resolve problems and complain about social care* and factsheet 66, *Resolving problems and making a complaint about NHS care*.

14 Hospital discharge – legislation and guidance

- **Discharge from mental health inpatient settings**

www.gov.uk/government/publications/discharge-from-mental-health-inpatient-settings/discharge-from-mental-health-inpatient-settings

- **Health and Care Act 2022**

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

- **Hospital discharge and community support guidance**

<https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance>

- **National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, July 2022**

www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

- **NICE Guidance NG27: Transition between inpatient hospital settings and community or care home settings for adults with social care needs**

www.nice.org.uk/guidance/ng27

Useful organisations

Alzheimer's Society

www.alzheimers.org.uk

Telephone helpline 0333 150 3456

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

Helpline 0808 196 3651

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.

Carers UK

www.carersuk.org

Helpline 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

Provides advice or information about claims for Disability Living Allowance, Personal Independence Payment or Attendance Allowance.

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>

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

Homecare Association

www.homecareassociation.org.uk

Telephone 020 8661 8188

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

Hospice UK

www.hospiceuk.org

The national voice of hospice care in the UK. They have a web-based postcode hospice finder.

Local Government and Social Care Ombudsman

www.lgo.org.uk

Telephone 0300 061 0614

Investigates complaints about local authorities and social care providers.

Macmillan Cancer Support

www.macmillan.org.uk

Helpline 0808 808 00 00

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

Marie Curie

www.mariecurie.org.uk

Support line 0800 090 2309

Offers care guidance and support to people living with a terminal illness.

MIND

Mind.org.uk

Infoline 0300 123 3393

Charity offering advice and support about mental health issues.

NHS website

www.nhs.uk

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

Royal Voluntary Service

www.royalvoluntaryservice.org.uk/

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

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.wales

0300 303 44 98

In Northern Ireland contact

Age NI

www.ageni.org

0808 808 75 75

In Scotland contact

Age Scotland

www.agescotland.org.uk

0800 124 42 22

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Next update November 2026

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