



October 2008

Key Points:

- Replaces previous version dated October 2007
- Includes information about the National Framework for NHS continuing healthcare and April 2008 rates for NHS-funded nursing care

Hospital discharge arrangements

This factsheet is aimed at people aged 60 and over.

This factsheet describes the situation in England. Readers in Northern Ireland, Scotland and Wales should contact their respective national Age Concern offices for information specific to where they live.

The Scottish Helpline for Older People – Age Concern Scotland, tel: 0845 125 9732 (local call rates) Monday to Friday, 10am – 4pm; website: www.olderpeoplescotland.co.uk;

Age Concern Cymru, Ty John Pathy, Units 13/14 Neptune Court, Vanguard Way, Cardiff CF24 5PJ, tel: 029 2043 1555 (national call rate); website: www.accymru.org.uk.

Contact details for **Age Concern Northern Ireland**: 3 Lower Crescent, Belfast BT7 1NR, tel: 028 9032 5055 (national call rate), Monday to Friday 10am – 12pm and 2pm – 4pm, website: www.ageconcernni.org.

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Introduction

This factsheet explains how your discharge should be managed following NHS treatment so that you obtain the help you need, in the most appropriate location. It describes how your needs are assessed and your eligibility for help is decided. The kind of help available, whether you might have to pay for it and what to do if you disagree with any decisions are also covered.

Health and social care professionals may use particular terms when talking about the support that can be offered. These are explained briefly below and are mentioned in the factsheet.

Community care services – this usually means support arranged by social services departments either in your own home or a care home. Care provided by NHS staff such as district nurses in your own home or in a care home may also be referred to in this way.

Continuing care - is a general term. It describes support provided to those aged 18 or older, over an extended period of time to meet physical and mental health needs that have arisen as a result of disability, an accident or illness. It may require services from the NHS and/or social services and can be provided in a range of settings.

Continuing health and social care – this support, available in a range of settings, may involve services from the NHS and social services.

NHS continuing healthcare – this is a package of care arranged and funded solely by the NHS. It is often referred to as “fully funded NHS care” and may be provided in a range of settings. It could be in a hospital, a care home, a hospice or your own home. If care is to be provided in a care home, accommodation, personal care and health care is funded by the NHS. If care is to be provided in your own home, the NHS funds your personal care and health care.

NHS-funded nursing care - is paid by the NHS to care homes providing registered nurse care to their residents. It relates to care provided by a registered nurse and/or involving input from a registered nurse in a supervisory role.

Intermediate care - this is care based around a care plan specially designed to maximise your independence and typically aims to allow you to return home after a hospital stay or to avoid admission to hospital.

Services may be provided by the NHS and/or social services and are free for up to six weeks.

There are other factsheets and information sheets (see Section 10) that go into more detail about the services available and legislation relating to the roles and duties of the NHS and local authorities.

1. Hospital discharge - the legal framework

The process described in this factsheet applies to NHS funded treatment in either an NHS or private hospital. See the information in Section 2.1 if your hospital treatment is not funded by the NHS.

You cannot be formally discharged from hospital until your medical condition is stable and you can be safely moved. Until then, a named doctor, usually your consultant is responsible for your care. If you are in a community hospital, this doctor could be a GP.

The *Community Care (Delayed Discharges etc) Act 2003*

This Act aims to encourage the NHS and social services to work together to ensure services are available when you leave hospital - whether you are to go home or move into a care home.

The *Act* describes procedures to be followed before an adult patient is discharged from an *acute* hospital bed. Patients in an 'acute' bed are likely to have come into hospital for planned treatment or received treatment following emergency admission. Patients whose discharge is not covered by the *Act* are referred to later in this section.

The NHS must alert social services if they believe you are likely to need community care services when you leave hospital. You may hear hospital staff refer to this as a 'section 2 notification'. Social services must be notified again once a discharge date is confirmed. Hospital staff may refer to this as a 'section 5 notification'.

If your discharge is delayed because social services fail either to assess your needs and/or provide a suitable care package within the timescale laid down in the *Act*, they must reimburse the NHS for each day's delay.

Guidance¹ issued in support of the *Act* stresses that:

- the *Act* requires the NHS body to consult with the patient before making a referral to social services.... (para 93);
- full involvement of patients and their carers in both assessment and care planning has long been recognised as good practice and included in guidance.... (para 96);
- if the patient is clear that they do not want the involvement of social services and that they will not accept services put in place for them, at this stage the patient becomes responsible for arranging their own onward care... (para 94);
- patients and carers should be informed of the discharge date at the same time as, or before, social services (para 108);

The *Act does not apply to the following types of care:*

- mental health care, where the person primarily responsible for the patient's hospital care is a consultant psychiatrist or psychogeriatrician (such care would usually be provided in a psychiatric hospital or unit);
- palliative care (see Section 4.2);
- intermediate care (see Section 4.1);
- non acute care in a community hospital or step down bed;
- treatment in an English hospital if you are ordinarily resident in Wales, Scotland or Northern Ireland.

If your discharge is delayed following a period of this type of care, no financial penalty is imposed on social services.

The Delayed Discharges (Continuing Care) Directions 2007

These apply to patients covered by the *Community Care (Delayed Discharges etc) Act 2003*. They relate to steps that NHS staff must take if they believe you may be in need of NHS continuing healthcare. These steps may be taken in consultation with social services but must be taken before the hospital notifies social services that you may need their help on discharge.

¹ HSC 2003/009: LAC (2003)21 *The Community Care (Delayed Discharges etc) Act 2003* Guidance for implementation. This Guidance was issued as Directions and is legally binding and must be complied with.

The steps to be taken are explained in more detail in see Section 3.1 NHS Continuing Healthcare.

The NHS Continuing Healthcare (Responsibilities) Directions 2007

These apply to individuals not covered by the *Community Care (Delayed Discharges etc) Act 2003* or who live at home. They require reasonable steps to be taken to ensure an NHS continuing healthcare assessment is carried out where there appears to be a need for such care.

2. Hospital discharge - the process

The aim of an effective discharge process should be to ensure:

- you do not stay in hospital longer than necessary;
- that a timely and comprehensive care package is offered in a setting that maximises your independence.

Discharge from hospital: pathway, process and practice is a 'best practice' workbook issued in 2003 by the Department of Health. It does not have the same status as legislation but hospitals should take account of it when they develop their hospital discharge procedures.

Listed in para 1.4 of this workbook are key principles that should be at the heart of an effective discharge policy. They include:

- discharge is a process and not an isolated event. It has to be planned for at the earliest opportunity ensuring that individuals and their carer(s) understand and are able to contribute to care planning decisions as appropriate;
- the engagement and active participation of individuals and their carer(s) as equal partners is central to the delivery of care and in the planning of successful discharge;
- the process should be co-ordinated by a named person who has responsibility for co-ordinating all stages of the patient journey;
- hospital and social care staff should work together as appropriate to manage all aspects of the discharge process.

If you wish for the NHS or social services to be involved when you are discharged, the process should include the following stages:

- 1. providing information about the discharge process;**
- 2. assessing your needs (and those of your carer);**
- 3. deciding your eligibility for NHS continuing healthcare;**
- 4. deciding your eligibility for support from social services and/or the NHS;**
- 5. drawing up a care plan;**
- 6. assessing your ability to pay for non-NHS services;**
- 7. implementing and monitoring your care plan.**

2.1 Providing information about the discharge process

The best practice workbook, referred to in Section 2, says that “a good discharge policy will ensure patients and their carers are provided with both verbal and written information on what to expect and on their contribution to the discharge process. Information should take into account any sensory or language needs of patients and their carers.”

Planned admissions

When discussing treatment options, it can be helpful to ask how the proposed surgery or treatment may affect your ability to go about your life as usual when you go home. This can help you understand what to expect and prepare for on your return home.

The workbook promotes the idea of a ‘pre-admission’ assessment if you are to have a planned operation. This allows early identification of and planning for any short or longer term health or social care support you are likely to need on discharge. It also provides an opportunity to ask for information about the discharge process.

Unplanned admissions

If you are admitted in an emergency, it will be in your best interests for the discharge process to start as soon as possible. This will ensure any package of care can be anticipated and planned for. You or a relative or carer, should ask for information about the discharge process as soon as possible.

Ward-based care co-ordinator

Good communication between you, your carer (if you have one) and staff involved in your care is essential.

The *best practice workbook* supports the appointment of a 'ward-based care co-ordinator' who is responsible for co-ordinating the steps necessary for a timely discharge. This is particularly vital for patients who will need support from health and/or social services on discharge.

It says 'the name of the ward-based co-ordinator should be clear to all involved in the patient's care and clearly documented in the patient's notes. Patients, their carers and/or relatives should be aware of who this individual is and how to contact him or her.'

Contact the hospital Patient Advice and Liaison Service (PALS) if you do not receive information from hospital staff about the discharge process. They should be able to provide this information or indicate who to contact to receive it. PALS have been set up to provide information and advice to patients and in many cases can be found in a prominent place in the hospital, such as the entrance or reception area. NHS Direct has details for your hospital PALS. See Section 9.

If your hospital treatment is not funded by the NHS

You or your insurance may fund your planned operation in a private hospital. The hospital will have its own discharge procedure and should be able to explain how your care following discharge will be managed. You may find it useful to ask for written details about this when confirming your admission date.

When discussing treatment options, it can be helpful to ask your consultant how long you are likely to stay in hospital and about any difficulties you might have once at home.

If you are likely to need social care support on discharge, you are entitled to have your care needs assessed by your home local authority even if your treatment is not funded by the NHS.² Social services staff will not be based in the hospital, so an assessment of your care needs, can present practical problems.

² *NHS and Community Care Act 1990*, section 47(1) states that your Local Authority (LA) has a duty to assess when your circumstances have come to the knowledge of the LA and you appear to be someone for whom social services can be provided and who might benefit from community care services.

Contact your local authority social services department as soon your admission date is known. The more notice and background information you can give social services, the easier it will be to ensure you receive help when you leave hospital. Social services may ask you to contact them again once you have been admitted but they will be forewarned of your potential need for support. You may be required to pay towards the costs of any services provided. See Section 2.6.

If a relative plans to stay with you for a time once you are discharged, you may be able to have a care assessment when you return home. This should allow time to put a care plan in place before your relative leaves.

2.2 Assessing your needs (and those of your carer)

You have a right to a care assessment whether you or social services is to fund any ongoing support you need. The information it provides will ensure all your needs are provided for whether you are to go home or move into a care home.

The assessment

Assessment means collecting information to help those responsible for your discharge understand more about your circumstances and needs - personal care needs, health needs including needs for nursing care and emotional and psychological needs - and how they affect your independence, daily living and quality of life.

Listening to your views and wishes (and where appropriate those of your carers) should therefore be a central part of the assessment process and ultimately any decisions that are made.

If you do not have relatives or close friends to support you, you may want an independent person (an advocate) to help you through the process and ensure your views and needs are clearly expressed. If English is not your first language, you may want an interpreter present.

The person co-ordinating your assessment should be able to help you find an advocate and/or arrange an interpreter. In some areas your local Age Concern will have an advocacy service.

In order to provide a complete picture, various health and social care professionals may need to conduct their own assessments. This may include an occupational therapist, speech therapist, physiotherapist, mental health nurse or dietitian.

If an occupational therapist is involved and you are likely to be able to return home, a home visit may be suggested. This allows consideration to be given to your home environment and the fitting of aids or special equipment that could be helpful.

The ward based care co-ordinator (see Section 2.1) or whoever is appointed to support your discharge will have a key role to play in ensuring the assessment process meets an agreed timetable.

Carer's role and carer's assessment

With your permission, your carer and or relatives can be invited to contribute to your assessment.

Your carer can also ask for a separate carer's assessment to identify any services they may need to support them in their caring role. Discharge staff should not assume your carer's ability and/or willingness to care for you. For more information on a carer's rights to assessment and services, contact Carers UK (see Section 9).

If you cannot contribute fully to an assessment and/or make or communicate your views about your future care, best practice suggests carers and family should be involved as much as possible. This might be the case if you have had a stroke or have dementia. In these circumstances, local authorities and the NHS have a responsibility to make decisions in your 'best interests', taking into account your known wishes and beliefs.

If you do not have mental capacity to make major decisions about your personal welfare, such as a move to a care home, and do not have relatives or unpaid carers who can be consulted, *The Mental Capacity Act 2005 (England and Wales)* requires an Independent Mental Capacity Advocate (IMCA) to be appointed by the person responsible for making such a decision. The IMCA's role would be to seek information about what would be in your best interests, represent your interests and challenge any decision that does not appear to be in your best interests.

This *Act* also allows you, while you have mental capacity, to appoint someone under a Lasting Power of Attorney (LPA) to take decisions about your health and/or personal welfare issues should you lose capacity to make such decisions in the future.

If you would like more information on IMCAs, LPAs or other aspects of the *Act*, the Office of Public Guardian has further information or see Factsheet 22 *Arranging for others to make decisions about your finances or welfare*. See Sections 9 and 10.

For more information about the assessment process, see Factsheet 41, *Local authority assessment for community care services*.

2.3 Deciding your eligibility for NHS continuing healthcare

NHS continuing healthcare, also referred to as fully funded NHS care, is a package of care arranged and funded solely by the NHS. A definition can be found in the Introduction. Each PCT will have a manager responsible for NHS continuing healthcare.

The majority of patients leaving hospital will not have needs that suggest eligibility for NHS continuing healthcare. However if you do have substantial health needs, the processes detailed in the National framework for NHS continuing healthcare and NHS-funded nursing care should be followed under the direction of your PCT. Any decision the PCT makes about your eligibility for NHS continuing healthcare should be recorded in your notes. If you are unhappy with the PCT decision, see Section 8.1.

If the recommendation is that you are not eligible, the team making this recommendation should indicate, with reasons, your need for registered nursing care in a care home registered to provide nursing care. See Section 3.2. However before admission to a care home is considered, your ability to return home with an appropriate care package should be considered.

The process is explained briefly in Section 3.1 and in more detail in Factsheet 20, *NHS continuing healthcare, NHS-funded nursing care and intermediate care*.

2.4 Deciding your eligibility for support from social services and/or the NHS

If your need for hospital care is over but you are not ready to return home or move into a care home, you may be eligible for a period of *intermediate care*. This is a time limited period of rehabilitation support and is explained in more detail in Section 4.1.

If you are not eligible for NHS continuing healthcare or intermediate care, you may still need support from social services and/or the NHS.

To decide what community care services may be arranged for you by social services, your assessed needs are compared with your local authority's eligibility criteria. See Section 3.3.

Any NHS services required to meet your assessed needs are arranged through your consultant and / or GP See Section 4.2.

If you have questions about how eligibility decisions have been reached, you may wish to see a copy of your assessment and the criteria used. If your questions are not answered satisfactorily and you remain dissatisfied with the decision, you can ask for details of the local authority complaints procedure.

See Section 3.3 of this factsheet for information about local authority eligibility criteria, Section 4 for details of the range of help that may be available and Section 8 for information about resolving disputes about decisions. Factsheet 41, *Local authority assessment for community care services* is also useful.

2.5 Drawing up a care plan

Your care plan aims to address how and where your eligible needs can best be met. Your views on what you hope can be achieved and where you would like to live should, where possible, be taken into account when drawing up your care plan. Your family, your carer or an IMCA may be involved in discussions about your future care. (See Section 2.2).

If you would prefer to return home, services that might be offered to allow this should be considered before it is suggested you move into a care home.

If you will require financial support from your local authority and your long term care needs could be met equally well through care at home or care in a care home, your local authority can legitimately offer the option which is cheapest for it to arrange or provide.

If you are to move into a care home registered to provide nursing care but did not pass the threshold for considering eligibility for NHS continuing healthcare, your nursing needs will be identified by a registered nurse. See Section 3.2.

If moving to a care home is a proposed option, you may wish to read Sections 2.6 and 6.

If you are awarded NHS continuing healthcare, your care plan and the care package to be provided is one which the PCT thinks is appropriate to meet your needs.

Your care plan may involve one or more of the following:

- moving from an acute ward to a 'step down' bed in the same hospital or to a community hospital;
- a period of intermediate care - see Section 4.1;
- rehabilitation services – see Section 4.2. If you are to receive these at home, additional support from a relative or carer and/or from social services may also be provided;
- an interim care package that will operate while any modifications are made to your home or while waiting for a bed in the care home of your choice to become available;
- a temporary stay in a care home;
- short or long term home care services to support you, and if appropriate your carer, once you return home – see Section 4.3;
- support from a district nurse or other community based NHS staff;
- access to community equipment (aids or minor adaptations);
- going to live with a relative with or without support from social services;
- NHS continuing healthcare in a care home or your own home;

- moving into a care home not registered to provide nursing care (formally known as a residential home) - this may be funded by yourself or with help from social services;
- moving into a care home registered to provide nursing care (formally known as a nursing home) - this may be funded by yourself or with help from social services. Care you need from a registered nurse will be funded by the NHS (see Section 3.2);
- move to sheltered housing with or without support from social services;
- respite or palliative care services as needed – see Section 4.2.

You should receive a copy of your care plan and with your permission, your relatives can request a copy too. You should also be told the name of the person to speak to if you disagree with any aspect of the proposed care plan and/or services to be offered. The detail of your care plan should be in proportion to your needs and the complexity of the services to be provided. It could include:

- what help you will be given and its purpose;
- who will provide the help, how often and when;
- details of what your carer is willing to do, their needs and how they will be supported in their role;
- who is co-ordinating your care plan;
- who and the number to contact in an emergency;
- who to contact if services are not meeting your needs;
- how much, if anything you will have to pay towards the cost of services, this is discussed in Section 2.6;
- monitoring arrangements for the care package and a date to review your package.

2.6 Assessing your ability to pay for non-NHS services

Paying for care at home

Your local authority can charge for services they arrange or provide to help you stay in your own home. Each local authority can decide whether it wishes to charge for these services and, if so, how much. In setting its own charging policy, it must comply with minimum requirements described in Government guidance. See Factsheet 46 *Paying for care and support at home*.

Social services can make **direct payments** to you, instead of providing services in your own home, if you meet certain criteria. Direct payments are made in lieu of services, so if your local authority has used its discretion to charge you for services, your direct payment will reflect the amount you have been calculated as able to pay. Direct payments can give more flexibility and control as you can decide how your assessed needs are met.

Your carer may also receive direct payments in her/his own right.

For more information on direct payments, see Factsheet 24, *Direct payments from social services*.

Note: NHS services cannot currently be provided through direct payments.

If you can afford to pay for services, social services staff have a duty to arrange services you have been assessed as needing if that is what you want them to do. You may find it easier if social services make these arrangements for you.

Paying for care in a care home

If it is decided your needs will best be met in a care home, a financial assessment - looking at both your income and savings - will be carried out if you are seeking local authority help with the fees. This means-test is completed according to national rules and is described in Factsheet 10, *Local authority charging procedures for care homes*. A financial assessment should be carried out independently of the care assessment, although it may be done at the same time.

If a financial assessment indicates you must fund your own care in a care home, Government guidance says the local authority must satisfy itself that you are able to make your own arrangements. If you cannot arrange your own care home place, the local authority has no power to oblige a relative or other interested party to do it for you - that person should be willing and able to do so. It also says that if you wish to make your own arrangements you should be advised about what type of care you require and informed about what services are available.

2.7 Implementing your care plan

See Section 5 if you are to be discharged home and Section 6 if you are to move into a care home.

2.8 Practical considerations for effective discharge

In addition to having a suitable care plan and ensuring services are in place on the day you leave hospital, there are practical points to consider:

- has your carer been informed of the date/time of your discharge?
- if a relative is not collecting you, will you need hospital transport?
- has suitable transport been identified and arranged?
- have medication needs been agreed and explained to you and where appropriate your carer? Have any special needs, such as need for large print labels or help with taking your medication as prescribed, been addressed? Do you know how long you will be taking the medication and how to request further supplies?
- have you and/or your carer received training, so that new aids or equipment can be safely and effectively used? Will these aids be available for use on day of discharge?
- have continence products been provided to meet assessed needs?
- has your GP and other relevant community health care staff been informed of your discharge date and which health services you will need immediately? Have they received the necessary health records and information about any medication changes?

- if a care home place has been arranged, has the care home been advised of your discharge date/time? Will your care plan and medication and other necessary health information be available to the care home on your arrival?

3. Eligibility for services

Each Strategic Health Authority (SHA) and its PCTs will have agreed with each local authority within their boundary what their respective responsibilities are for the provision of the full range of health and social care services.

If you are in hospital away from the area where you live

You may have to go into hospital while on holiday or visiting family and friends or may have selected a hospital via 'Choose and Book' that is closer to your family and so some distance away from your home. You may be having specialist planned NHS treatment only available in a hospital some distance from your home.

In such cases the rule is that if you need support on leaving hospital, it is the PCT area in which your GP practice is located that dictates who is responsible for arranging and funding NHS services, including fully funded NHS care. Responsibility for arranging social care services lies with the local authority in which your usual address (or the address of your main residence) falls.

3.1 NHS continuing healthcare

The National Framework for NHS continuing healthcare and NHS-funded nursing care sets out clear principles and processes to be used by all PCTs for establishing a primary health need, which in turn indicates eligibility for NHS continuing healthcare. Three tools have been produced to provide consistency and transparency to the process.³

The ***fast track pathway tool*** is to help professionals outline reasons for a decision to fast track a patient with a rapidly deteriorating condition, which may be entering a terminal phase, for immediate provision of NHS continuing healthcare.

³ The national framework for NHS continuing healthcare and NHS-funded nursing care
http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Continuingcare/DH_079276

The ***NHS continuing healthcare checklist tool*** is to help professionals decide whether full consideration of your eligibility is needed. The threshold for full consideration has been set deliberately low so that all who may be eligible are included. On completion of the checklist you should be told the outcome and reasons for the decision reached. If it is decided a full consideration is not necessary, you can request a full assessment. The PCT should give due consideration to this request and any information you wish to add and inform you of the outcome.

If a full consideration is recommended, you should have a comprehensive needs assessment, involving relevant health professionals and social services if appropriate. This should allow the completion of the decision-support tool.

The ***decision-support tool*** supports the process of establishing a primary health need. It identifies eleven areas that can give rise to health needs, with each area having descriptive statements to indicate different levels of need. The aim is to match your needs in each of the areas, with the statement that most closely reflects your situation. There is also space in the paperwork for you or your carer to record your views of your needs.

The eleven areas are: behaviour, cognition, psychological and emotional needs, communication, mobility, nutrition and hydration, continence, skin and tissue viability, breathing, drug therapies to control symptoms and altered states of consciousness. The areas and levels reflect the nature, complexity, intensity and unpredictability of needs. Those completing the tool must justify the level of need they have chosen for each area.

The completed decision-support tool, guidelines indicating the threshold needed to constitute a primary health need and the professional judgement of the multi-disciplinary team (MDT) who will make a recommendation to the PCT are all used to ensure an informed decision is made. The completed tool should also indicate whether you/your family were invited to or declined to attend the MDT meeting and whether you/they have seen and/or agree with the completed document. Only in exceptional circumstances should the MDTs recommendation not be followed.

Although it is relatively complex exercise, the process is more transparent than the one followed previously and you or your relatives can contribute to and ask to see the paperwork. A helpful glossary is attached to the paperwork. If you wish to challenge the decision, see Section 8.1.

Your care plan will be one that the PCT believes is appropriate to meet your needs.

If the NHS subsequently provides any part of your ongoing care, a case review will be undertaken no later than three months following the initial assessment, and then as a minimum on an annual basis. This review is to reassess your care needs and eligibility for NHS continuing healthcare and to ensure those needs are being met. It will take place even if, following application of the checklist, you did not receive a full consideration of your eligibility for NHS continuing healthcare.

A decision that you are no longer eligible for NHS continuing healthcare can be made at a later date if your health needs change.

Factsheet 20 *NHS continuing healthcare, NHS-funded nursing care and intermediate care* gives more detail.

3.2 NHS-funded nursing care in a care home

NHS-funded nursing care is the funding paid directly to care homes registered to provide nursing care (formally known as nursing homes), to support the care provided by a registered nurse to eligible residents. See the Introduction for a definition of this care. Nursing homes have a registered nurse on the premises at all times and employ their own nurses. This payment is the responsibility of the PCT in whose area the care home is located

Your nursing care needs can be decided in one of two ways:

- By the multi disciplinary team – should they recommend that you are not eligible for NHS continuing healthcare but are likely to need care in a care home registered to provide nursing care. There is space on the decision-support tool for your nursing needs to be recorded.

- By a registered nurse involved in assessing your needs – should you have health needs on leaving hospital that do not indicate you may be eligible for NHS continuing healthcare.

The National Framework says that in all cases, a decision about eligibility for NHS continuing healthcare must be made before considering the need for NHS-funded nursing care.

A single rate for nursing care was introduced on 1st October 2007. Before then, a three band (low, medium and high) system operated. Changing to a single rate was part of the implementation of the National Framework for NHS continuing healthcare and NHS-funded nursing care.

Residents who were in a nursing home on 1st October 2007 and on the low or medium band moved automatically to a single rate of £101 per week. Those who were on the high band had their needs re-assessed and if they still met the criteria for the high band remained on this band and continued to receive £139 per week.

Anyone entering a nursing home on or after 1st October 2007 automatically attracts the single rate.

In August 2008 increases to these rates, which are backdated to 1st April, were announced. The flat rate increases to £103.80 per week and the high band to £142.80. The increases are in line with the nurses annual pay award.

Note: A payment for nursing care is not made on behalf of residents of care homes not registered to provide nursing care (formally known as residential homes). Any nursing care these residents require from a registered nurse is provided by a nurse who visits the home such as a district nurse, not a nurse employed by the home.

3.3 Social care services

There are no *national* eligibility criteria for community care services. Each local authority sets its own criteria and so there are differences around the country. Fair Access to Care Services (FACS) guidance sets out a framework for determining eligibility criteria which local authorities should respect when setting their own⁴.

⁴ LAC (2002) 13 Fair Access to Care Services - guidance on eligibility criteria for adult social care.

The FACS framework suggests four bands of eligibility - critical, substantial, moderate and low - representing the seriousness of the risk to an individual's independence if problems and issues are not addressed. Local authorities should prioritise needs based upon their immediate and longer term consequences for the individual's independence if the need is not addressed.

The FACS guidance advises that the evaluation of that risk should focus on the following aspects of independence:

- autonomy and freedom to make choices;
- health and safety including freedom from harm, abuse and neglect, taking wider issues of housing and community safety into account;
- the ability to manage personal and other daily routines;
- involvement in family and wider community life.

Your assessed needs are compared with your local authority's eligibility criteria, which are usually reviewed before the start of each financial year. If you disagree with decisions about your eligibility that cannot be resolved, there is a formal complaints procedure. See section 8.3.

4. Support services

The following section describes the type of help that could be available on a temporary or long term basis from:

- intermediate care services;
- the NHS;
- the local authority social services department;
- voluntary agencies;
- private domiciliary care agencies.

4.1 Intermediate Care

Intermediate care may be offered if you would benefit from a short period of 'active' rehabilitation after acute hospital treatment. The aim would be to help you regain confidence and physical skills that would allow you to return home or maximise your independence in a care home.

Intermediate care is intended to be limited to a maximum of six weeks and may be for as little as one to two weeks. It may be provided in a care home, community hospital, a day care facility or your own home and may involve different health care professionals and social care staff.

No charge should be made for health or social care services provided as part of an 'intermediate care' package^{5 6}.

Please note: If there isn't a vacancy in the care home of your choice, intermediate care is not the same as 'interim' care. For more information about interim care see the subsection 'if there is no vacancy in the home of your choice' within Section 6.

4.2 NHS services

Rehabilitation and recovery services

Rehabilitation services are NHS services that aim to promote your recovery and maximise your independence if, for example, you have had a heart attack or a stroke. Services may begin before or after you leave hospital, can continue for weeks or months and may involve a range of health professionals offering services such as speech therapy to help with speech or swallowing or physiotherapy to help with mobility.

Note: There are similarities between rehabilitation and intermediate care but intermediate care will start once you have finished your acute hospital treatment, may involve help from social services and is strictly time limited.

Palliative care

Palliative care describes the holistic care offered when you have an advanced progressive illness that is no longer responding to treatment. Palliative care services may be offered in your own home, in a hospice or while in a care home. They may include controlling and managing pain and other physical symptoms and providing emotional support for patients and their family during and following an illness. They are designed to keep you comfortable and ensure the best quality of life for you and your family.

⁵ HSC 2001/01 : LAC (2001) 1 Intermediate Care

⁶ LAC (2003) 14 Changes to local authority charging regime for Community equipment and intermediate care services

Palliative care services might include support from Macmillan nurses, Marie Curie nurses or hospice support teams.

Other NHS services

You will be eligible to receive and should not be charged for:

- support from a GP and/or practice based staff such as a district nurse to provide general medical follow up care;
- support from specialist healthcare professionals such as continence advisers, stoma care specialists, physiotherapists;
- continence pads (if you have been assessed as needing them);
- specialist medical and nursing equipment;
- respite health care. PCTs must arrange and fund an adequate level of respite health care for people who have intensive or complex health care needs, requiring specialised or intense nursing attention or who need active rehabilitation during their period of respite care.

Respite care is only the responsibility of the NHS if you meet the requirements described in the above bullet point. In most cases, respite care to enable a carer and the cared-for person to have a short break is the responsibility of social services.

You may be offered respite care in a care home or in your own home using a sitting service or skilled care workers such as those provided by Crossroads. When a need for respite care is identified, health and social services must agree who funds the care needed. If it is a social services responsibility, you may be asked to contribute towards the cost.

4.3 Social care services

These might include personal care such as helping you to get washed and dressed or ready for bed, meals delivered to your home, respite care, a place at a day centre or a place in a care home. Social services might provide these services themselves or purchase them from a private or voluntary agency.

Social services can arrange for the fitting of community equipment such as grab rails and loan of items such as raised toilet seats or shower chairs.

The *Community Care (Delayed Discharges etc) Act 2003* regulations require that 'any item of community care equipment for which a person or their carer is assessed as needing as a community care service and for which they are eligible, is required to be provided free of charge. All minor adaptations costing £1,000 or less (which includes the cost of buying and fitting the adaptation) are required to be provided free of charge. Councils retain the discretion to make a charge in relation to minor adaptations that exceed £1000 to provide'.

4.4 Voluntary organisations

Voluntary organisations, such as Age Concern, may offer a range of services including home visiting and befriending, advocacy and an information and advice service. They may run day centres or luncheon clubs or provide respite services. In some cases they provide these services under contract from social services.

In some areas, voluntary organisations have advisers based full or part time in hospitals who provide information or support to those about to be discharged. Organisations such as local Age Concerns and the Red Cross may offer '*home from hospital*' support' either independently or with the knowledge of or under contract from social services or the local hospital.

These schemes offer help with non-medical tasks such as:

- shopping
- light housework
- cooking a meal
- providing companionship

Not all local groups provide the same range of services, so you will need to contact your local group or organisation for details of how they may be able to help. (See Sections 9 &10).

4.5 Private domiciliary care agencies

Private care agencies offer a range of personal care services and some may offer meal preparation and help with domestic tasks. Any care agencies or voluntary organisations offering personal care (any care that involves close personal and physical contact) must be registered with and are inspected by the Commission for Social Care Inspection (CSCI). Care agency inspection reports are available on the CSCI website. See Section 9.

If you elect to receive Direct Payments from social services you may choose to buy your care from private care agencies. For more information see Section 2.6 in this factsheet and Factsheet 24, *Direct payments from social services*.

In some cases your local social services department will provide lists of local agencies. UK Home Care Association can give you details of care agencies including those that can provide live-in carers. See Section 9.

5. Discharge to your own home

You should not be discharged until:

- you are medically fit;
- your home care package has been agreed and services are ready to start as soon as you arrive home.

If you are to receive care from social services, you and your carer or a nominated person should be told of your discharge date at the same time as or before social services.

If you are ready for discharge home but need minor adaptations made to your home or equipment such as a hoist or grab rails fitted, it may be necessary for 'interim' or 'transitional' care arrangements to be agreed. For information on 'transitional'/'interim' care, see *if there isn't a vacancy in the home of your choice*, in Section 6.

Guidance issued in support of the *Community Care (Delayed Discharges etc) Act 2003* says 'if a patient is discharged from hospital or intermediate care to a home care package, whether as an interim measure or long-term basis, social services should check the adequacy of the care package within at most two weeks of discharge... to ensure they are not at risk of a deterioration in their condition or readmission to hospital.' If you are living alone this should ideally be within a few days of discharge.

A review of your care needs should then be carried out at an agreed interval or at least annually.

6. Discharge to a care home

Your assessment may indicate that going into a care home - on a temporary or permanent basis - would best suit your needs. If a care home is suggested you may first wish to read Factsheet 29, *Finding care home accommodation* and Factsheet 10, *Local authority charging procedures for care homes*. They contain useful information, including the issues raised briefly below.

Choosing a care home

If your local authority's social services department is arranging and paying towards your care home place you can choose which home you will live as long as the following conditions are met⁷:

- the home is assessed as being suitable for your assessed care needs;
- the home is willing to enter into a contract with the local authority, subject to the local authority's usual terms and conditions;
- the home costs no more than the local authority would normally pay for someone with those assessed needs;
- there is a vacancy.

In many cases, a care home manager will want to visit you in hospital before agreeing to accept you as a resident.

You can choose to enter a home that costs more than the local authority normally pays for someone with your assessed care needs if there is a 'third' party, such as a relative, willing to pay a 'top up' to cover the difference. In limited circumstances, the 'top up' can be paid by you⁸.

However the local authority cannot set a price ceiling, then demand a 'third party' payment if no care home place is available in a home that can meet your needs at or below this price. See Information Sheet 25 *Choice of Accommodation – Care Homes*.

⁷ Local Authority Circulars LAC (92)27, LAC (93)18, LAC (2001)25 and LAC (2001)29. Choice of Accommodation

⁸ You can pay your own top up a) if you qualify for a 12 week disregard of your property when you first enter a care home on a permanent basis or b) as part of a deferred payment agreement with your local authority. See Factsheet 10, *Local authority charging procedures for care homes* for more information.

If you are funding your own care home place, you or your family can, having decided the level of fees you are willing to pay, choose a care home. Each home should produce a brochure and a statement of purpose. This together with the findings of your care assessment will help in making a decision.

You may also like to request a copy of an Office of Fair Trading (OFT) publication “Fair Terms for Care” which aims to help you decide whether the terms of a care home contract are fair. Contact details for the OFT can be found in Section 9.

Regulations require care homes to specify the fees payable for the standard services they offer; the arrangements for paying such fees; and the arrangements for charging and paying for any additional services⁹. These regulations also require them to:

- announce changes in fee levels, if it is practicable, at least one month in advance, together with a statement of reasons for any increase;
- specify whether services, terms and conditions and fees vary according to the source of funding for a person’s care. The aim being to alert prospective residents to seek further information – for instance whether fees paid by those funded by the local authority differ from those paid by people funding their own care.

In the case of nursing homes, the information about fees should relate to the total fees payable before account is taken of any nursing contribution paid by the PCT. See Section 3.2.

If you are arranging and funding your own care home place, you may be eligible to claim attendance allowance - see Information Sheet 13, *Care home funding and attendance allowance*.

If your place in a nursing home is fully funded by the NHS, guidance on Choice of Accommodation mentioned above does *not* apply. This means that, providing the care the NHS is offering is clinically suitable, you do not have the right to choose the location or care home in which you will receive care. Your/your family’s views should be taken into account but there is no right to choose the location of your care.

⁹ The *Care Standards Act* (Establishments and Agencies) (Miscellaneous Amendments) Regulations 2006

If you are funding your own care home place and your health deteriorates so that you become eligible for NHS continuing healthcare and your current care home is still able to meet your needs but is more expensive than the NHS would normally pay for someone with your assessed needs, you would need to discuss whether it is possible to stay there. The effect on your physical and mental health of moving from your current care home would need to be taken into account before any decision is made to move you to a cheaper home. If your continuing healthcare needs can no longer be met in your current care home, this would also need further discussion with the person who advised you of the decision to award fully funded care or with the continuing care manager/co-ordinator at the PCT.

If you are funding your own care home place but subsequently need to apply to the local authority for financial support with care home fees your current home may be more expensive than the local authority would normally pay to meet your assessed needs. This is discussed in Section 13 of Factsheet 10, *Local authority charging procedures for care homes*.

Note: You can seek financial help from your local authority once your capital falls below the upper capital limit of £22,250 (amount in England for financial year commencing April 2008). You should approach them several months before you reach this amount to allow time for a care and financial assessment to take place.

If there isn't a vacancy in the care home of your choice

If you are ready to be discharged and your chosen home has no vacancy or is not likely to have a vacancy in the near future, *The Community Care (Delayed Discharges etc) Act 2003* guidance says:

- in many cases where patients cannot immediately move on from acute care, whether they are waiting for a place in a care home, for family members, carers or an advocate to visit and be involved in any decisions, or for home adaptations to be completed, NHS and social care staff should take a joint approach to providing interim arrangements which allow the patient to move from an acute hospital bed. This interim care could be a period of intermediate care, NHS step-down care provided in a non acute bed or extra support in a person's own home.

For persons who require care in a care home, it is established good practice that where possible people should not move directly from a hospital to a care home for the first time, but should have a period of time to make personal arrangements and adjust (para 104);

- options for interim care should be considered and offered based on assessed needs, with a full explanation to the patient of the terms of the interim package, including any charges which may apply. Councils should take all reasonable steps to gain an individual's agreement to an interim care package, that is, to provide a care package with which an individual is satisfied. As with a permanent care package, if an individual continues to unreasonably refuse an interim care package which the council has offered, having taken the patient's circumstances into account, the council is entitled to consider that it has fulfilled its statutory duty to assess and offer services, and may then inform the individual they need to make their own arrangements.' (para 105).

In these circumstances, you may be asked to make a temporary move and be asked to pay towards services arranged or provided by the social services department. This is the case, regardless of whether your place is to be funded by yourself or social services.

When deciding whether it is appropriate for you to move to interim accommodation while waiting for a vacancy, your emotional wellbeing and the risks of moving would need to be considered.

While such a move can be distressing, it is recognised that once clinically fit to be discharged, it is rarely in the best interests of a patient who is keen to maintain their mobility, independence and sense of autonomy, to have an extended stay on a busy hospital ward.

The Discharge from Hospital workbook proposes in Section 7.6 'Trusts should have in place agreed policies and procedures to address situations in which patients or their families refuse a move from an acute hospital bed to another setting.' If you find yourself in this position, you may wish to ask if there is a hospital policy.

If you do not want to go into a care home

The local authority has a duty to meet your eligible needs. Sometimes it will decide that your needs should be met in a care home because this is the only alternative. However, if it is making a financial contribution to the cost of your care, it may also be because it is the cheaper option. Where your needs could be met equally well through different service options, the local authority can legitimately offer the option that is cheapest to arrange or provide. Often there will be financial limits to how much care will be provided in your own home. For further information see 'negotiating over care' in Factsheet 41, *Local authority assessment for community care services*.

You cannot be forced to go into a care home. However, if after a thorough discussion of options, you unreasonably refuse to accept a place in a care home, social services is entitled to consider it has fulfilled its statutory duty to assess and offer services and may inform you that you need to make your own care arrangements. In order to consider it has fulfilled its statutory duty, social services should be able to show that a patient refusing a care package has persistently and unequivocally refused services, not simply refused them on a single occasion.

You could, however, argue that a care home would not meet your needs. A 1994 court judgement, *R v Avon County Council ex parte M*, established that these must include psychological needs.

Sheltered housing to rent or buy may be an option, although there is often a waiting list for these schemes. Some schemes including one called 'extra care', can provide additional services such as home care or meals. The Government is encouraging the development of 'extra care' schemes but they are not yet widely available. For further information see Factsheet 50, *Housing Options* or contact the Elderly Accommodation Counsel see Section 9.

Right to refuse discharge to a care home

If you have been assessed as *not* requiring further acute care or NHS continuing healthcare, you do not have the right to occupy a NHS bed indefinitely. However, a local authority does not have a general power to insist you go into a care home against your will. There are a few exceptions to this and you should seek further advice if you have concerns.

If you refuse to enter a care home you *cannot* insist on staying in hospital, so the question arises of what happens next - ie where you might move to live, and what sort of care you would receive.

In such cases, the local authority social services department should work with hospital and community staff, you, your family and any carer(s) to explore alternative options. You may be asked to pay towards services arranged or provided by the social services department in this context.

Trusts are advised in Section 7.6 of the *Discharge from Hospital* workbook 'to have agreed policies and procedures in place to address situations in which patients and their families refuse a move from an acute hospital bed to another setting'.

7. If your care needs change

If your health deteriorates significantly, you should ask for a new assessment of your needs. It could mean that you become eligible for additional care at home, for moving into a care home or a care home providing nursing care or for NHS continuing healthcare.

8. Disputes and complaints

8.1 Review of NHS continuing healthcare decisions

If you are dissatisfied with the way your PCT has applied the National Framework and followed the processes required to reach a decision you can ask for the decision to be reviewed. Local resolution is usually the first step, unless this would add unnecessary delay. Local resolution may involve convening a review panel from your own PCT or from a neighbouring PCT. If, having exhausted local resolution, you still wish to challenge the decision because of the procedure followed or reasoning used to reach the decision, your case should be referred to the SHA for an independent review.

While the review is conducted, the PCT should continue to fund appropriate care. Any existing care package, whether hospital care or community services should not be withdrawn under any circumstances until the outcome of the review is known.

The review procedure does *not* apply if you want to challenge the type and location of any offer of NHS funded continuing care services *or* the content of any alternative care package that has been offered.

The independent review process

Following a request for a review, the SHA must notify, in writing, the standing chairman or reserve standing chairman that a request for a review has been received. The SHA may then refer the matter to an independent review panel for advice.

A panel has three members: a *standing/reserve standing chairman* appointed by the SHA, *one person from a PCT in the SHA area* but not the PCT whose decision is the subject of the review and *one person from a local authority in the SHA area* but not one covering the same area as the PCT that is subject to the review.

A timeframe for the review process should be decided and you and/or your family told what this is to be. Those arranging the review should, as far as possible, allow for involvement of the patient and / or their carers. This includes offering the opportunity to submit information. The panel should seek appropriate professional advice from hospital and or community staff relevant to the case.

The SHA should let you, or the person requesting the review, have written details of the review panel's decision, with reasons, as soon as possible. Other relevant parties - the PCT and/or hospital trust – should also be told. The role of the panel is advisory but its decisions should be accepted by the PCT in all but exceptional circumstances.

If the original decision is upheld and despite additional discussion you still wish to challenge it, your case should be referred to the Healthcare Commission (HC). This should be explained to you when you receive the decision of the independent review panel.

Healthcare Commission

The HC can usually only review your complaint if you have completed the independent review stage outlined above. To learn more about how the Commission might handle your complaint, contact their complaints helpline on: 0845 601 3012 (lo-call rate) or go to the patient and the public section on their website:

<http://www.healthcarecommission.org.uk/homepage.cfm>

Health Service Ombudsman

If you remain dissatisfied following a review of your complaint by the Healthcare Commission, you can refer the matter to the Health Service Ombudsman. The Ombudsman's office does not have to investigate every complaint. It will usually expect the local resolution and independent review stages to have been completed by the PCT/SHA, unless it would be unreasonable to expect you to do so. See section 9

8.2 Making a complaint about NHS services

If you are unhappy about your hospital care or how your discharge was dealt with, you can use the NHS complaints procedure. The hospital PALS can provide information about the process.

PALS can also try and help resolve issues at an early stage, before they escalate to a formal complaint. You may therefore like to approach PALS if, having raised concerns as they arise with ward staff involved in your discharge, you remain unhappy. If your issues cannot be resolved this way, PALS should be able to tell you who to address your complaint to in the first instance and who to write to if you wish to make a formal written complaint. They can also give details of your local ICAS (Independent Complaints Advocacy Service).

If you wish to make a complaint to the NHS that includes issues relating to social services too, the NHS can, with your permission, transfer any relevant part of a complaint to the local authority. You should be told which part of your complaint the local authority would handle. This will save you having to make a separate complaint.

8.3 Making a complaint about social services

Social services departments are required by law to have in place a formal complaints procedure that you can use if you are not satisfied with the help offered or the quality of service provided. Each department should have a designated complaints officer and provide details of how to contact that person on request.

9. Further information

Alzheimer's Society, Devon House, 58 St Katharine's Way, London E1W 1JX. Helpline: 0845 300 0336 (lo-call rate), website: www.alzheimers.org.uk. Supports people with all types of dementia, families and carers; provides information about all forms of dementia and issues affecting those with dementia. It also runs local groups for people with dementia and their relatives.

Bladder and Bowel Foundation (formerly Continence Foundation and Incontact) SATRA Innovation Park, Rockingham Road, Kettering, Northants NN16 9JH, tel: 01536 533 255, nurse helpline: 0845 345 0165 (lo-call rate), website: www.bladderandbowelfoundation.org. Provides information and nurse helpline as well as having local support groups.

British Red Cross, 44 Moorfields, London EC2Y 9AL, tel: 0844 412 2804 (lo-call rate), website: www.redcross.org.uk. Services mainly provided by volunteers and available from local centres including transport and escort, medical loan, domiciliary care, Home from Hospital schemes.

Carers UK, 20 Great Dover Street, London SE1 4LX. Carers' Line tel: 0808 808 7777 (free call), website: www.carersuk.org. General help and advice for all carers.

Commission for Social Care Inspection (CSCI), 33 Greycoat Street, London SW1P 2QF, helpline: 0845 015 0120 (lo-call rate), website: www.csci.org.uk. Registers and inspects care services including care homes and homes care agencies in England. If you are unhappy with the response of a regulated care service to any concern or complaint raised with them, you can share this information with the Commission who will decide what action may be necessary.

Elderly Accommodation Counsel, 3rd Floor, 89 Albert Embankment, London SE1 7TP, tel: 020 7820 1343, website: www.housingcare.org. Provides information and advice about all forms of accommodation for older people. It can also provide lists of care homes and sheltered housing schemes with accommodation to rent or buy in all parts of the United Kingdom. Once you have located a possible housing provider you will have to contact them directly to confirm details such as availability and how to apply.

Hospice Information, St Christopher's Hospice, 51-59 Lawrie Park Road, Sydenham, London SE26 6DZ, and Help the Hospices, Hospice House, 34-44 Britannia Street, London WC1X 9JG, tel: 0870 903 3903 (national call rate) or 020 7520 8222, website:

www.hospiceinformation.info/index.asp. Hospice information is a partnership between St Christopher's Hospice and Help the Hospices offering an enquiry service to the public and professionals on UK and International palliative care.

NHS Direct, 0845 46 47 (lo-call rate) is the 24 hour NHS helpline. It can give details on areas covered by each SHA and PCT in England; details of the NHS complaints procedure, Patient Advice and Liaison Service (PALS) and local ICAS service.

Office of Fair Trading, Fleetbank House, 2-6 Salisbury Square, London EC4Y 8JX, tel: 020 7211 8000, enquiry line: 08457 22 44 99 (lo-call rate), website: www.offt.gov.uk. The booklet 'Fair Terms for Care' can be ordered by writing to OFT PO Box 366 Hayes UB3 1XB or calling 0800 389 3158 (free call).

Office of the Public Guardian, Archway Tower, 2 Junction Road, London N19 5SZ, customer services: 0845 330 2900, website: www.publicguardian.gov.uk. The booklet *Making Decisions: A guide for family, friends and unpaid carers*, can be downloaded from their website. Copies of the booklet are available from customer services while stocks last. Forms and guidance can be downloaded from the website,

Parliamentary and Health Service Ombudsman (The), Millbank Tower, Millbank, London SW1P 4QP. Complaints helpline: 0845 015 4033 (lo-call rate), website: www.ombudsman.org.uk.

Patients Association, PO Box 935, Harrow, Middlesex HA1 3YJ, helpline: 0845 608 4455 (lo-call rate), general admin tel: 020 8423 9111, website: www.patients-association.com. It is a registered charity. It offers advice to patients and carers on patients' rights, complaints procedures and access to health services or appropriate self-help groups.

Stroke Association, Stroke House, 240 City Road, London EC1V 2PR, tel: 020 7566 0300 or helpline: 0845 30 33 100 (lo-call rate), website: www.stroke.org.uk. Provides advice and information on all aspects of stroke illness. Community services include family support service, dysphasia support service and a regional information service.

UK Home Care Association (UKHCA), Group House, 2nd Floor, 52 Sutton Court Road, Sutton, Surrey SM1 4SL, helpline: 020 8288 5291, website: www.ukhca.co.uk. Homecare agencies which subscribe to the UKHCA code of practice can be found on their website or by calling their helpline. This includes agencies that can provide live-in carers.

10. Further information from Age Concern

The following fact/information sheets are also relevant:

Factsheet 6	<i>Finding help at home</i>
Factsheet 10	<i>Local authority charging procedures for care homes</i>
Factsheet 20	<i>NHS continuing health care, NHS-funded nursing care and intermediate care</i>
Factsheet 24	<i>Direct Payments from social services</i>
Factsheet 29	<i>Finding care home accommodation</i>
Factsheet 41	<i>Local authority assessment for community care services</i>
Factsheet 46	<i>Paying for care and support at home</i>
Factsheet 50	<i>Housing options</i>
Info Sheet 13	<i>Care home funding and attendance allowance</i>
Info Sheet 25	<i>Choice of accommodation - Care Homes</i>

The following books may be useful:

Your Rights to Healthcare gives advice on helping older people get the best from the NHS. Price £7.99.

Find the Right Care Home: a step-by-step companion. Price £9.99

To order, please telephone our hotline (9am-7pm Monday to Friday, 9am-5pm Saturday): 0870 44 22 120 (national call rate), or visit our website: www.ageconcern.org.uk/bookshop (secure online bookshop).

If ordering by post, please send a cheque or money order, payable to Age Concern England, for the appropriate amount plus p&p to Age Concern Books, Linhay House, Linhay Business Park, Ashburton, Devon TQ13 7UP.

(Postage and packing: mainland UK and Northern Ireland: £1.99 for the first book, 75p for each additional book up to a maximum of £7.50. Free on orders over £250. For customers ordering from outside the mainland UK & NI: credit card payments only; please telephone the hotline for international postage rates or email: sales@ageconcernbooks.co.uk).

If you would like

- to find your nearest Age Concern
- any additional factsheets mentioned (up to a maximum of 5 will be sent free of charge)
- a full list of factsheets and/or a book catalogue
- to receive this information in large print

phone 0800 00 99 66 (free call) or write to Age Concern FREEPOST (SWB 30375), Ashburton, Devon TQ13 7ZZ. For people with hearing loss who have access to a textphone, calls can be made by Typetalk, which relays conversations between text and voice via an operator.

Age Concern factsheets and other information materials can be downloaded free from our website at: www.ageconcern.org.uk. To receive free notification of factsheet updates and all information resources, subscribe to our monthly email *Your Information Update* at www.ageconcern.org.uk/infoupdate.

Age Concern provides factsheets free to older people, their families and people who work with them. If you would like to make a donation to our work, you can send a cheque or postal order (made payable to Age Concern England) to the Personal Fundraising Department, ACE Freepost CN1794, London SW16 4BR.

Find out more about Age Concern England online at www.ageconcern.org.uk.

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Whilst every effort is made to ensure accuracy, Age Concern cannot be held responsible for errors or omissions.

No factsheet can ever be a complete guide to the law, which also changes from time to time. Therefore please ensure that you have an up to date factsheet and that it clearly applies to your situation. Legal advice should always be taken if you are in doubt. (*Age Concern England is unable to give financial or legal advice*).

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