Day and Nightcare

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FULL HANDBOOK

Leaving hospital

What to expect, Discharge to Assess, reablement and the questions to ask before someone comes home.



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A short guide to this handbook, with the key points of each guide: **www.dayandnightcare.co.uk/leaflets/brochure-leaving-hospital-short.pdf**

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CQC overall rating: Good (report published 20 April 2018)

This PDF was made on 1 November 2026. Where a page records when its information was last checked, the date is at the end of that page. Information, not advice: please check anything important with the organisation named.

Leaving hospital: what to expect and how to prepare

Last updated 30 October 2026; sources last checked 30 October 2026.

IN BRIEF

In England, hospitals start planning your discharge soon after you arrive, and most people go home with little or no new support. If you need help, short-term support is arranged so you can recover at home first and have any longer-term needs assessed there, an approach called Discharge to Assess. Families can help most by asking early about the date, the plan and who will pay.



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How hospital discharge works in England

Hospitals in England follow the government's statutory **Hospital Discharge and Community Support Guidance** (last updated in January 2024). Its central idea is simple: a hospital ward is not a good place to recover or to decide what someone

will need in the long term. Once a person no longer needs the care only a hospital can give, they should leave, and any longer-term needs should be assessed after they have had time to recover, ideally at home.

This is called **Discharge to Assess (D2A)**, and many areas describe it as "home first". In practice it means:

- planning for discharge starts on admission, or before a planned operation
- for emergency admissions, the team should set an estimated discharge date and destination within 48 hours and share it with the patient and, with their agreement, the family and unpaid carers
- doctors and nurses review every patient on a general ward each day against a short list of "criteria to reside" (for example, needing oxygen, a drip or intensive monitoring); when none applies, the team should actively plan the discharge
- big decisions about long-term care, such as a permanent move into a care home, should not normally be made in hospital

Since July 2022, the law has required NHS hospital trusts to involve patients and their unpaid carers, including young carers, in discharge planning as early as possible.

The four discharge pathways

The guidance sorts discharges into four pathways. Knowing which one is planned helps you understand what will happen next.

- **Pathway 0: home with no new care.** The ward arranges a simple discharge. Someone may restart a care package they already had, at the same level, or get help from a voluntary "home from hospital" service. Most people leave this way.
- **Pathway 1: home with new or extra support.** Organised through the local care transfer hub. This might be reablement, home-based rehabilitation, a restarted care package or new care visits, while longer-term needs are worked out.
- **Pathway 2: a short stay in a community bed.** Time-limited rehabilitation in a community hospital, rehabilitation unit or care home, before going home or moving on.

- **Pathway 3: a care home, for the most complex needs.** Used only rarely. People should not go straight from hospital into a permanent care home for the first time except in exceptional circumstances; the first placement is usually for assessment.

You can read more about how assessments and funding work in Discharge to Assess explained.

Who is on the discharge team

Several people are involved, and it helps to know who does what:

- **The ward nurse or nurse in charge:** day-to-day care and often your first point of contact.
- **The consultant and ward doctors:** decide when someone is medically ready to leave.
- **Physiotherapists and occupational therapists:** assess walking, transfers, stairs, washing and dressing, and recommend equipment.
- **The ward pharmacist:** checks medicines and prepares the supply to take home.
- **Discharge coordinators or discharge liaison nurses:** organise the practical arrangements.
- **Social workers and the care transfer hub:** a team (sometimes virtual) that arranges support for more complex discharges. Everyone whose discharge goes through the hub should have a named case manager.

Ask for the name and direct number of the person coordinating the discharge. It saves a great deal of chasing.

Timing: when will they come home?

Discharge dates often move. Common reasons for delay include waiting for a doctor's review, test results, medicines from the pharmacy, transport, equipment or a care package. Many hospitals use a discharge lounge, so the person may leave the ward hours before they actually go home.

Typical timescales to expect:

- **Within 48 hours of an emergency admission:** an estimated discharge date and destination should be set.

- **Every day:** doctors review whether the person still needs to be in an acute bed.
- **On the day:** medicines from the pharmacy and transport often take several hours, so afternoon or early evening arrivals are common.
- **On the day of discharge:** anyone needing formal support should have an initial safety and welfare check.
- **Up to six weeks:** the usual length of free reablement or intermediate care.
- **About 28 days:** the usual time for an NHS Continuing Healthcare decision once a positive checklist has been received.

If you are arranging private care, give the provider the expected date as soon as you have it, and ask the ward to ring you the moment it changes.

Documents and information to have ready

Bring these to the ward, or keep them on your phone:

- the person's NHS number and GP surgery details
- a list of the medicines they took before admission
- a copy of any registered Lasting Power of Attorney, or the access code from the GOV.UK "Use a lasting power of attorney" service
- any advance care plan, advance decision or ReSPECT form
- details of any existing care package or care provider
- names and numbers of the family members to keep informed
- the key safe code, and who holds spare keys
- a short note of what the person could do before the admission, and what help they had

Getting home: transport and the first day

The guidance asks hospitals to arrange transport home through family, friends, voluntary services or a taxi where possible. NHS patient transport is kept for people who have a medical need for it.

Before the day, check that:

- there are house keys, warm clothes and suitable shoes for the journey
- the heating is on and there is food, milk and drinks in the house
- any key safe code has been shared with the people who need it

- someone will be there, or will call, on the first evening

Medicines to take home

Most people leave with a supply of medicines, sometimes called TTOs ("to take out"). Before leaving, ask:

- which medicines are new, which have stopped and which doses have changed
- how many days the supply will last and how to get more from the GP
- whether the medicines can be put in a weekly dosette or blister pack if that helps
- whether a referral has been made to the **NHS Discharge Medicines Service**, which lets the hospital pass details of changes to your community pharmacy so they can check everything matches

The hospital should also send the GP a discharge summary. Ask for your own copy, and give one to any care provider supporting with medicines.

Equipment and adapting the home

Therapists may recommend equipment such as a walking frame, raised toilet seat, perching stool, commode, bed rails or a hospital bed. Community equipment is usually lent free of charge: when someone is assessed as needing them, councils must provide aids, and minor adaptations costing up to £1,000, without charge. Ask when the equipment will be delivered: ideally before, or on, the day of discharge. If stairs are a problem, a bed may need to be set up downstairs for a while.

What families can do

- Tell the ward, early, who should be kept informed, and make sure the patient agrees.
- Share what life was like before the admission: what the person managed alone, what help they had, and what worries you.
- Ask which discharge pathway is planned and what support it includes.
- Ask who pays for each part of the support, and for how long.
- Mention any Lasting Power of Attorney and bring a copy.
- Raise concerns in writing if you think a plan is unsafe.
- Look after yourself: if you will be providing care, ask for a carer's assessment.

Our questions to ask before hospital discharge checklist puts all of this in one place.

Words you can use

It can be hard to know how to put things on a busy ward. You are welcome to adapt these:

- **Asking about funding:** "Please could you confirm in writing what support has been arranged, who is paying for each part, the date any free period ends, and the name and number of our contact?"
- **Asking about NHS Continuing Healthcare:** "Mum's needs are complex and changing. We would like NHS Continuing Healthcare to be considered. Will a checklist be completed, and if it will be done after discharge, when and by whom?"
- **Raising a worry about the plan:** "We are worried the plan is not safe because Dad lives alone and has fallen twice at night. Please can the plan be reviewed before he goes home, and can our concerns be written in his notes?"
- **Asking for a carer's assessment:** "I will be helping to care for my husband when he comes home. Please can I be referred for a carer's assessment?"

Who to call if something goes wrong after discharge

Keep this list by the phone for the first few weeks:

- **The named contact or care transfer hub** on the discharge paperwork: if care visits do not arrive or the plan is not working.
- **The GP surgery:** for medicines, new symptoms or a medication review.
- **NHS 111:** for urgent health advice day or night.
- **The council's out-of-hours emergency duty team:** for urgent social care problems at night or weekends.
- **999:** in an emergency.
- **The hospital's Patient Advice and Liaison Service (PALS):** if you have concerns about how the discharge was handled.

Arranging private care quickly

Some families choose to arrange care privately, either because they want a particular provider, more hours than are on offer, or simply the certainty of knowing who will be there. To do this well:

- contact providers as soon as the expected discharge date is known
- check that each provider is registered with the Care Quality Commission (CQC) and look at its rating
- share the therapy and nursing assessments (with the person's consent) so the provider understands the needs
- ask about start dates, continuity of carers, what the care includes and the notice period
- ask the discharge team to record your private arrangement in the plan

If you have savings above the council's upper limit (£23,250 in England in 2026/27) and need care at home, you can still ask the council to assess your needs and arrange care for you; it may charge a fee for arranging it. Check too whether Attendance Allowance could help with the cost.

Going home with live-in care

For some people, the safest way home is with a carer who lives in. A live-in carer can be there from the first evening, which matters because the first nights after hospital are often when people feel most unsteady, confused or anxious.

Live-in care can help with getting up and moving around safely, personal care, prompting medicines, meals and drinks, and simply being there, while working alongside reablement workers, district nurses and therapists. It can be short term while someone regains strength, or the start of longer-term support. The home needs a spare bedroom for the carer.

Live-in care is not right for everyone. Someone who needs two people to move them through the night, or frequent nursing, may need a different arrangement, and for some people a care home is the better choice. A good provider will tell you honestly. See care after a hospital stay for how it works.

What to do next

1. Ask the ward for the expected discharge date, the planned pathway and the name of the discharge coordinator.
2. Tell the team who should be kept informed and share what life was like before the admission.
3. Ask who will pay for any support, and for how long, and write the answers down.
4. Check medicines, equipment and transport a day or two before the expected date.
5. If you want private or live-in care, contact providers now rather than on the day.

How we can help

Since 2014 we have provided Discharge to Assess (D2A) care, and for several years we ran Oxfordshire's Urgent Response service, so we know how quickly hospital discharges move. We provide live-in care anywhere in England, from £1,550 a week, and home care visits, waking nights and sleep-ins across Oxfordshire. Our free initial assessment includes talking with you, your family and the hospital team about what is needed at home. We can often start within 24 to 48 hours of the assessment, depending on carer availability, and we confirm the start date once a carer is arranged. Call us on 01865 715780 as soon as you have an expected discharge date.

Common questions

Can a hospital send someone home without care in place?

The hospital should not discharge someone who needs support until a safe plan is in place, but nobody has a legal right to stay in a hospital bed while waiting for a particular care provider or care home. If your first choice is not available, you should be offered a suitable short-term alternative. National guidance also says anyone who needs formal support should have a safety and welfare check on the day they go home. If you believe the plan is unsafe, tell the ward and discharge team clearly, ask for it to be reviewed, and contact the hospital's Patient Advice and Liaison Service (PALS).

How much notice will we get before someone is discharged?

You should be told an estimated discharge date early, usually within 48 hours of an emergency admission, but the final day is often confirmed at short notice. Discharges depend on test results, a doctor's review, medicines being ready and support being in place, so the date can move in either direction. Ask the ward for the expected date and destination as soon as you can, ask to be phoned when it changes, and start any private care arrangements in good time rather than waiting for the final confirmation.

Who pays for care after leaving hospital?

It depends on the support and on where you live. Reablement and intermediate care arranged by the council or NHS are free for up to six weeks, and some areas fund other short-term care while you are assessed. NHS Continuing Healthcare is free if you are eligible. Care that continues after the short-term period is usually means-tested by the council, and private care is paid for by you. Always ask who is paying, from when and until when, and ask for the answer in writing.

Can we arrange our own care instead of the care the hospital offers?

Yes. You can choose to arrange and pay for your own care, such as live-in care or extra visits, and many families do when they want a particular provider or more support than is on offer. Tell the discharge team early so they can plan around it, and check what free support you might be giving up. You can also accept free reablement and add private care alongside it, which often works well in the first weeks at home.

What happens if the person has dementia and cannot decide where to live?

If someone lacks the mental capacity to decide where to live after hospital, the decision must be made in their best interests under the Mental Capacity Act 2005. The team must involve the person as much as possible and consult the family and anyone who knows them well. If there is a registered Lasting Power of Attorney for health and welfare, the attorney makes the decision. If there is nobody suitable to consult, an independent advocate should be appointed.

Sources and further information

- GOV.UK: Hospital discharge and community support guidance
- NHS: Planning to leave hospital

- NHS: Care to support recovery after leaving hospital
- NHS England: NHS Discharge Medicines Service
- GOV.UK: Care and support statutory guidance
- NICE NG27: Transition between inpatient hospital settings and community or care home settings

Read next

LEAVING HOSPITAL AND RECOVERY

Discharge to Assess (D2A) explained for families

What Discharge to Assess (D2A) means in England: the four pathways, which care is free and for how long, what happens when the D2A period ends, assessments for council funding and NHS Continuing Healthcare, and how to plan ahead.

Read the guide →

LEAVING HOSPITAL AND RECOVERY

Questions to ask before hospital discharge: a checklist

A practical checklist of questions to ask the ward, the discharge team, the pharmacist, the GP and the care provider before someone leaves hospital, covering the plan, medicines, equipment, funding, follow-up and what to do if something goes wrong.

Read the guide →

LEAVING HOSPITAL AND RECOVERY

Reablement and intermediate care: free help to recover

Reablement and intermediate care help people recover after a hospital stay, a fall or an illness. Find out what is free (up to six weeks), who provides it, how goals are set, how to get it without a hospital stay, and what happens afterwards.

Read the guide →

All guides in the information centre Check what help you could get

This page online: **www.dayandnightcare.co.uk/guides/leaving-hospital-what-to-expect/**
Guide last reviewed 30 October 2026.

Discharge to Assess (D2A) explained for families

Last updated 30 October 2026; sources last checked 30 October 2026.

IN BRIEF

Discharge to Assess (D2A) means leaving hospital as soon as you no longer need hospital care, with short-term support at home or in a community bed, and having your longer-term needs assessed once you have had time to recover. Some D2A support is free for a limited time, but since 2022 the funding rules have been set locally, so always ask who is paying and until when.



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1. What Discharge to Assess means
2. The D2A pathways in brief
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What Discharge to Assess means

Discharge to Assess, usually shortened to D2A, is the way hospitals in England now organise discharge. The idea is that people should leave hospital as soon as they no longer need hospital care, with whatever short-term support they need, and that

decisions about their long-term care should be made **after** they have had a chance to recover.

There are good reasons for this. A hospital ward is an unfamiliar, tiring place, and many older people become weaker or more confused the longer they stay. Someone assessed on a ward may look far less able than they will be a few weeks later in their own kitchen. Assessing them at home, once they have settled, gives a fairer picture and avoids decisions, such as a permanent care home place, that might turn out to be unnecessary.

D2A is set out in the government's **Hospital Discharge and Community Support Guidance**, which is statutory guidance for NHS bodies and councils in England.

The D2A pathways in brief

- **Pathway 0:** home with no new care, or an existing care package restarted at the same level.
- **Pathway 1:** home with new or extra short-term support, such as reablement, home-based rehabilitation or care visits.
- **Pathway 2:** a short stay in a community bed (a community hospital, rehabilitation unit or care home) to recover.
- **Pathway 3:** a care home for people with the most complex needs, used rarely and normally first for assessment rather than as a permanent move.

Our guide to leaving hospital explains each pathway and who is involved.

What is free, and for how long

This is the question families ask most, and the honest answer is that it depends on where you live and what support is given.

During the pandemic, the government paid for a set period of free care after discharge, first up to six weeks and later up to four weeks. That national scheme ended on 31 March 2022, which is why you may still hear people talk about "four weeks free". Today, each area agrees its own funding arrangements between the NHS and the council, often using pooled budgets such as the Better Care Fund.

Some things are free by law, wherever you live:

- **Reablement and intermediate care** arranged by the council must be free for up to six weeks, whatever your savings. The statutory guidance says these services should not have a strict time limit, and that councils should consider keeping them free beyond six weeks where there is a clear benefit.
- **Aids, and minor adaptations costing up to £1,000**, provided by the council after an assessment.
- **NHS Continuing Healthcare (CHC)**, for people whose needs are mainly health needs, which covers the full cost of care.
- **Aftercare under section 117 of the Mental Health Act**, for people who were detained under certain sections.
- **Interim NHS-funded care while CHC is being decided**, where the NHS has put this in place. The national framework says such interim services should continue until the decision is made, with no gap in support.

Other short-term D2A care may also be free locally for a set period, but this varies. Care that continues after the D2A period is usually **means-tested**. In England in 2026/27, people with capital above £23,250 normally pay the full cost of council-arranged care, and those with capital below £14,250 have that capital ignored. The value of the home you live in is not counted when care is provided at home.

What happens at the end of the D2A period

As the short-term support comes to an end, there should be a review of how the person is managing. The outcome is usually one of these:

- no further support is needed
- ongoing care at home is arranged by the council, after a care needs assessment and a financial assessment
- the person or family arranges private care
- the person is found eligible for NHS Continuing Healthcare
- a move to a care home is agreed, if home is no longer right

The guidance says that where an area funds a recovery period, no one should be left without support when it ends. Ask, before it starts, how much notice you will get of the end date and what the charges will be afterwards, so there are no surprises.

Assessments for longer-term care

Several assessments may happen during or at the end of D2A:

- **Care needs assessment.** The council assesses whether the person has eligible needs under the Care Act 2014, using national eligibility criteria.
- **Carer's assessment.** Anyone who provides unpaid care is entitled to their own assessment. See our guide to the carer's assessment.
- **Financial assessment.** Works out what, if anything, the person pays towards council-arranged care. See council funding for care.
- **NHS Continuing Healthcare.** Usually starts with a screening checklist. The national framework says that in the vast majority of cases screening and full assessment should happen after discharge, in the community, because an assessment in an acute hospital is unlikely to reflect longer-term needs. The decision should normally be made within 28 days of the positive checklist. People who are rapidly deteriorating and may be entering a terminal phase can be fast-tracked. Read more in our NHS Continuing Healthcare guide.

Be there for assessments if you can, and describe the bad days as well as the good ones. A short diary of what help is needed, day and night, is often more persuasive than anything said on the day.

Typical timescales

- **Estimated discharge date:** within 48 hours of an emergency admission.
- **Safety and welfare check:** on the day of discharge, for anyone needing formal support.
- **Reablement and intermediate care:** usually up to six weeks, often one or two.
- **Local D2A funding:** varies by area; ask for the exact end date.
- **NHS Continuing Healthcare:** a decision normally within 28 days of the integrated care board receiving a positive checklist; Fast Track care usually within 48 hours.
- **Care needs and financial assessments:** no fixed national deadline, but they should be completed before any free period ends, so ask for dates.

Words you can use

Asking for the funding in writing (by email to the discharge coordinator or social worker):

> "Thank you for arranging support for my father, [full name] (NHS number [number]), on his discharge from [ward]. Please could you confirm in writing: what support has been arranged and by whom; which parts are free and which, if any, he will be charged for; the date any free period ends; when his longer-term needs will be assessed; and the name of our contact. Many thanks."

Asking for an NHS Continuing Healthcare checklist:

> "My mother's needs are complex and unpredictable, and we would like her to be screened for NHS Continuing Healthcare. If it is not appropriate to do this in hospital, please confirm when and where the checklist will be completed after discharge, and that interim support will continue until a decision is made."

Asking for notice before charges start:

> "Please let us know at least two weeks before the free period ends, with a copy of the financial assessment, so we can plan."

Documents for the financial assessment

If ongoing care may be arranged by the council, the financial assessment will go more smoothly if you have these ready:

- recent bank and building society statements for every account
- details of savings, investments and Premium Bonds
- State Pension, private pension and benefit award letters (including Attendance Allowance)
- details of any property other than the home

- the Council Tax bill and any housing costs
- receipts for disability-related expenses, such as extra heating, laundry or a community alarm, which can reduce what is charged
- a copy of any Lasting Power of Attorney or deputyship order, if someone is acting for the person

Common mistakes to avoid

- **Assuming everything is free.** Ask what is free, from when and until when, and get it in writing.
- **Assuming nothing is free.** Self-funders are still entitled to free reablement and to NHS Continuing Healthcare if eligible.
- **Agreeing to a permanent care home in hospital.** Long-term decisions are meant to be made after recovery.
- **Missing the end date.** If you are not told when free support stops, you may be charged without realising.
- **Not asking for a CHC checklist** when someone's needs are complex, unpredictable or rapidly changing.

How to challenge a decision

If you disagree with an assessment or a funding decision, ask for the reasons in writing and for a copy of the assessment. Council decisions can be challenged through the council's complaints procedure and then the Local Government and Social Care Ombudsman. NHS Continuing Healthcare decisions have their own review process, starting with the integrated care board (ICB). An independent advocate can help if the person finds it hard to take part.

How to plan ahead

D2A works best when families have thought ahead:

- Make a Lasting Power of Attorney while it is still possible, so someone can speak for the person if needed.
- Know roughly what savings and income the person has, so you can judge whether care is likely to be council-funded or self-funded.
- Talk about preferences: would they want care at home, live-in care or a care home if needs grew?

- Check what benefits they could claim, such as Attendance Allowance.
- Note the names of providers you would trust, so you are not choosing in a hurry.

What to do next

1. Ask the discharge team which pathway is planned and what support it includes.
2. Ask who is paying for each part, from when, until when, and request it in writing.
3. Ask for a review date and the name of the person responsible for the assessment.
4. Keep a simple diary of the help needed in the first weeks at home.
5. If you will want private care afterwards, speak to providers before the D2A period ends.

How we can help

Since 2014 we have provided Discharge to Assess care, so we understand how D2A works from the inside and the questions families need answered. We provide live-in care anywhere in England, from £1,550 a week, and home care visits, waking nights and sleep-ins across Oxfordshire, funded privately, by councils (including direct payments) or by NHS Continuing Healthcare. If you would like support to continue, or start, when D2A care ends, our free initial assessment is a good place to begin. Call us on 01865 715780.

Common questions

Is Discharge to Assess care free?

Often for a period, but there is no longer a single national free period. Reablement and intermediate care arranged by the council or NHS must be free for up to six weeks, and many areas fund other short-term care while assessments take place. NHS Continuing Healthcare is free if you qualify. Once the short-term period ends, any ongoing council-arranged care is usually means-tested. Ask the discharge team exactly what is free, from which date and until when, and ask them to put it in writing.

How long does the D2A period last?

There is no fixed national length. The aim is to support someone until they have recovered as much as they are likely to, or their needs have settled, so a fair assessment of long-term needs can be made. Intermediate care is usually delivered for no longer than six weeks and often for one or two weeks. Some people need only a few days; others need longer. Ask for a review date at the start so you know when decisions are expected.

Can we turn down D2A support and pay for our own care?

Yes. You can decline the support offered and arrange your own care, and some families prefer to because they want a particular provider or more help than is available. Before you decide, check what you would be giving up: free reablement, for example, can sit alongside private care rather than replacing it. Tell the discharge team your plan so it is recorded, and keep the door open to council or NHS assessments later.

Will the family home be sold to pay for care after D2A?

Not if care is provided at home. The value of the home you live in is ignored in the council's financial assessment for care at home. It may be counted if someone moves permanently into a care home, but not for the first 12 weeks, and not at all while a partner, or a relative aged 60 or over or who is disabled, still lives there. Deferred payment agreements can also mean nothing is sold during the person's lifetime.

What is the difference between D2A and reablement?

Discharge to Assess is the overall approach: leave hospital promptly, recover, then be assessed. Reablement is one of the services that can be offered within it, usually short-term visits at home from workers who help you relearn everyday tasks such as washing, dressing and making a drink. Other D2A support might be home-based therapy, a restarted care package, or a short stay in a community bed.

Sources and further information

- GOV.UK: Hospital discharge and community support guidance
- GOV.UK: Care and support statutory guidance
- GOV.UK: National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care

- legislation.gov.uk: Care and Support (Charging and Assessment of Resources) Regulations 2014, regulation 3
- NHS: Care to support recovery after leaving hospital
- NICE NG74: Intermediate care including reablement

Read next

LEAVING HOSPITAL AND RECOVERY

Leaving hospital: what to expect and how to prepare

How hospital discharge works in England today: the discharge pathways, who the discharge team are, timing, transport, medicines and equipment, what families can do, and how to arrange private or live-in care quickly.

Read the guide →

LEAVING HOSPITAL AND RECOVERY

Reablement and intermediate care: free help to recover

Reablement and intermediate care help people recover after a hospital stay, a fall or an illness. Find out what is free (up to six weeks), who provides it, how goals are set, how to get it without a hospital stay, and what happens afterwards.

Read the guide →

PAYING FOR CARE AND REDUCING THE COST

NHS Continuing Healthcare: a guide for families

A plain-English guide to NHS Continuing Healthcare in England: who qualifies, the Checklist, the Decision Support Tool and its 12 domains, Fast Track, care at home including live-in care, reviews, appeals with template letters, retrospective claims and how to prepare evidence.

Read the guide →

All guides in the information centre Check what help you could get

This page online: **www.dayandnightcare.co.uk/guides/discharge-to-assess-explained/**

Reablement and intermediate care: free help to recover

Last updated 30 October 2026; sources last checked 30 October 2026.

IN BRIEF

Reablement and intermediate care are short-term services that help you get back on your feet after a hospital stay, a fall or an illness. When arranged by the council or the NHS they are free for up to six weeks, whatever your savings, and the aim is to help you do things for yourself again rather than doing them for you.



IN THIS GUIDE

1. What is intermediate care?
2. What is reablement?
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5. Who can have it, and how to get it
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What is intermediate care?

Intermediate care is the name for a group of short-term services that help people recover, avoid unnecessary hospital stays and stay as independent as possible. National guidance from NICE describes four kinds:

- **Crisis response:** a rapid assessment and short-term help at home (usually up to 48 hours) when someone becomes unwell, to avoid a hospital admission.

- **Home-based intermediate care:** mainly health professionals, such as physiotherapists, occupational therapists and nurses, helping someone recover at home.
- **Bed-based intermediate care:** a short stay in a community hospital, rehabilitation unit or care home bed for people who are stable but not yet ready to go home.
- **Reablement:** mainly social care workers helping someone at home to relearn everyday skills and regain confidence.

NICE says intermediate care is usually delivered for no longer than six weeks, and often for just one or two weeks. In hospital discharge, these services make up most of what is offered on discharge pathways 1 and 2.

What is reablement?

Reablement is about doing things **with** you rather than **for** you. A reablement worker might stand beside you while you wash and dress, encourage you to make your own breakfast, practise the stairs with you, or help you work out an easier way to get in and out of the bath. At first they may do more; as you grow stronger they step back.

The aim is to rebuild skills and confidence after a setback, so you need less help in the long run, or none at all.

Who provides it

Intermediate care is planned jointly by the NHS and the council, so the team may include:

- physiotherapists and occupational therapists
- nurses and, sometimes, doctors or speech and language therapists
- social workers
- reablement or care workers, employed by the council or by a care provider it has commissioned

Most people receive it at home, though it can be provided in a community bed. NHS England has also asked every area to run an **urgent community response** service, available at least 8am to 8pm, seven days a week, that aims to reach people at home within two hours when they urgently need care.

Is it free?

Yes, for up to six weeks. Under the Care and Support (Charging and Assessment of Resources) Regulations 2014, councils in England cannot charge for intermediate care, including reablement, in the first six weeks. This applies to everyone, whether or not they have eligible needs for ongoing care, and whatever their savings.

The statutory guidance adds two important points:

- neither intermediate care nor reablement should have a strict time limit; the length should depend on the person's needs and goals
- councils can charge after six weeks, but should consider keeping it free where it is clearly helping and reducing the risk of hospital admission

Aids, and minor adaptations costing up to £1,000, are also provided free by the council when you have been assessed as needing them.

Who can have it, and how to get it

You may be offered intermediate care:

- as part of your discharge from hospital
- after a fall, injury or illness at home
- when daily life is getting harder and the right support could help you stay independent

NICE says people should not be excluded because of a particular condition, such as dementia, or because of where they live, such as a care home. If you think it could help and it has not been offered, ask the ward, your GP or the council's adult social care team for an assessment.

Words you can use when you phone the GP surgery or the council's adult social care team:

> "My mother, who is 84, has become much less steady since a chest infection and is struggling to wash, dress and get in and out of her chair. We think a short period of reablement could help her get back to how she was. Please could she be assessed for reablement or other intermediate care?"

Have ready: the person's NHS number, GP details, a list of what they find hard now compared with before, any recent falls or hospital visits, and who lives with them.

What to expect in the first week

- **An assessment visit**, often from a therapist or reablement coordinator, to see what the person can do now and agree goals.
- **A plan** showing the goals, how often workers will visit (sometimes several times a day at first) and roughly how long the service should last.
- **Equipment**, such as a perching stool, raised toilet seat or grab rails, arranged where needed.
- **Visits that change over time**: more support at the start, with workers stepping back as skills return.
- **Regular reviews**, often weekly, to update the goals.

Ask for a copy of the plan and the name and number of the coordinator.

Setting goals that matter

Good reablement starts with an assessment of what you can do now, and a conversation about what matters to you. Goals should be yours, in your words. For example:

- "I want to make my own cup of tea and lunch."
- "I want to wash and dress without help."
- "I want to walk to the post box and back."
- "I want to get upstairs to sleep in my own bed."

A simple way to keep track, which you can copy onto paper and keep on the fridge:

Goal	What will help	Review date
Make a hot drink safely	Kettle tipper, perching stool, practice each morning	End of week 1
Shower without help	Shower seat, grab rail, worker standing by	End of week 3

Goal	What will help	Review date
Walk to the post box	Daily walks, a little further each time	End of week 5

The plan should be reviewed regularly and changed if things are not working. NICE encourages "positive risk taking": balancing the benefits of doing something for yourself against the risks, rather than avoiding every risk and losing independence along the way.

How families can help reablement work

- **Hold back a little.** It is natural to want to do everything, but practising is how skills come back.
- **Share what normal looked like.** Tell the team what the person could do before, and what they enjoy.
- **Keep equipment in use.** A walking frame left in the hall does not help anyone.
- **Speak up early.** If the person is struggling, in pain or low in mood, tell the team so the plan can change.
- **Ask about the end date.** Find out when the service is due to finish, and what happens next.

What happens afterwards

Towards the end of reablement, the team should work with you and your family to agree next steps. Many people need no further help. Others need some ongoing support, and then:

- the council may carry out a care needs assessment and a financial assessment (see council funding for care)
- you can arrange care privately, for example a few visits a day or live-in care
- people whose needs are mainly health needs should be considered for NHS Continuing Healthcare
- you should be told how to refer yourself back if things change

Check whether benefits such as Attendance Allowance could help with the cost of any ongoing care.

When reablement may not be the right fit

Reablement is designed for people who are likely to regain skills. It may not suit someone who is very close to the end of life, or whose condition means they need consistent help with most things, day and night. In those situations, ongoing care, sometimes funded through the NHS Continuing Healthcare Fast Track, may be more appropriate. Reablement can also run alongside other care: for example, a live-in carer can support someone through the night and at weekends while the reablement team works on goals during the day.

What to do next

1. Ask whether reablement or another form of intermediate care has been considered.
2. Agree clear goals with the team, written in the person's own words.
3. Note the start date, the expected end date and the name of a contact.
4. Keep track of progress and raise concerns early.
5. Before the end, ask what support will follow, who will pay, and how to get help again.

How we can help

Since 2014 we have provided Discharge to Assess care, and for several years we ran Oxfordshire's Urgent Response service, so we understand how short-term recovery support fits together. If more help is needed when reablement ends, or alongside it, we provide home care visits, waking nights and sleep-ins across Oxfordshire, and live-in care anywhere in England from £1,550 a week. Our initial assessment is free. Call us on 01865 715780.

Common questions

Do I have to pay for reablement?

No, not for the first six weeks. The law in England says intermediate care, including reablement, arranged by the council must be free for up to six weeks, whatever your income or savings. Councils are allowed to charge after six weeks, but the statutory guidance asks them to consider keeping it free for longer where it is clearly helping, for example during rehabilitation after sight loss. If you are asked to pay during the first six weeks, ask the council to explain why.

Can I get reablement without going into hospital first?

Yes. Intermediate care is also meant for people living at home who are finding daily life harder because of illness or disability, or who are at risk of going into hospital. Ask your GP surgery or contact your council's adult social care team and ask for an assessment. If someone needs help urgently at home, the GP or NHS 111 can refer to the local urgent community response team, which aims to respond within two hours.

Can someone with dementia have reablement?

Yes. National guidance from NICE says people should not be excluded from intermediate care because they have a particular condition such as dementia, and that reablement should be considered for people living with dementia to help them keep and improve their independence. The approach may need adapting, with more time, familiar routines and simple, consistent prompts, but it can make a real difference.

What happens if I still need help when reablement ends?

Before reablement finishes, the team should agree the next steps with you. If you still need support, the council will carry out a care needs assessment and, if you have eligible needs, a financial assessment to work out what you would pay. You can also arrange private care, apply for benefits such as Attendance Allowance, or be screened for NHS Continuing Healthcare if your needs are mainly health needs.

Is reablement the same as home care?

No. Home care provides ongoing help with everyday tasks. Reablement is short term and aims to make itself unnecessary: workers encourage you to do as much as you can, so your skills and confidence come back. NICE recommends that reablement is offered first to people being considered for home care, where it could improve their independence. Some people have both, with reablement goals alongside a little ongoing care.

Sources and further information

- NICE NG74: Intermediate care including reablement
- NHS: Care to support recovery after leaving hospital, or after a fall, injury or illness
- GOV.UK: Care and support statutory guidance

- legislation.gov.uk: Care and Support (Charging and Assessment of Resources) Regulations 2014, regulation 3
- NHS England: Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge
- NHS England: Urgent community response services

Read next

LEAVING HOSPITAL AND RECOVERY

Discharge to Assess (D2A) explained for families

What Discharge to Assess (D2A) means in England: the four pathways, which care is free and for how long, what happens when the D2A period ends, assessments for council funding and NHS Continuing Healthcare, and how to plan ahead.

Read the guide →

LEAVING HOSPITAL AND RECOVERY

Leaving hospital: what to expect and how to prepare

How hospital discharge works in England today: the discharge pathways, who the discharge team are, timing, transport, medicines and equipment, what families can do, and how to arrange private or live-in care quickly.

Read the guide →

LIVING SAFELY AND WELL AT HOME

Equipment and home adaptations: what is free and how to get it

How to get equipment and home adaptations for an older or disabled person in England: occupational therapy assessments, free council and NHS equipment, Disabled Facilities Grants of up to £30,000, VAT relief, beds, hoists and stairlifts, and how to buy safely.

Read the guide →

This page online: **www.dayandnightcare.co.uk/guides/reablement-and-intermediate-care/**

Questions to ask before hospital discharge: a checklist

Last updated 30 October 2026; sources last checked 30 October 2026.

IN BRIEF

Before someone leaves hospital, ask the ward and discharge team about the date, the plan and who will pay; check medicines, equipment and follow-up; and make sure the GP and any care provider know what is needed. Asking early, and writing the answers down, prevents most of the problems families meet in the first days at home.



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1. Documents to take to the ward
2. Questions for the ward doctors and nurses
3. Questions about medicines
4. Questions for the discharge team or social worker
5. Questions about equipment and the home
6. Questions for the GP after discharge
7. Questions for a care provider
8. If the person cannot decide for themselves
9. If you are worried about the plan
10. Words you can use
11. Day of discharge checklist
12. Useful numbers
13. What to do next
14. How we can help
15. Common questions
16. Sources and further information

Keep this list on your phone or print it, and tick off questions as you go. You will not need to ask every one; choose the ones that fit. Write down who you spoke to, when, and what they said.

Documents to take to the ward

- the person's NHS number, GP surgery details and a list of the medicines they took before admission

- a copy of any registered Lasting Power of Attorney, or its online access code
- any advance care plan, advance decision to refuse treatment or ReSPECT form
- details of any existing care package, equipment or community alarm
- names and numbers of family members to keep informed (with the person's agreement)
- a notebook and pen for names, dates and answers

Questions for the ward doctors and nurses

- What happened, and what is the diagnosis now?
- Is the person medically ready to leave, and what is the expected discharge date?
- What has changed since the admission: walking, eating and drinking, continence, memory or mood?
- Are there any wounds, pressure areas or skin problems that need care at home?
- What signs of getting worse should we look out for, and who should we call?
- Are there follow-up appointments, tests or results still to come? Who will arrange them?
- Has anyone discussed what should happen in an emergency, such as a ReSPECT form or a decision about resuscitation (DNACPR)? If so, has it been explained to the person and the family?
- Has the person's ability to make decisions about their care been assessed, and how were they involved?

Questions about medicines

The ward pharmacist is often the best person to ask.

- Which medicines are new, which have stopped, and which doses have changed? Why?
- How many days' supply will be given, and how do we get more from the GP?
- Are there any side effects to watch for?
- Can the medicines be supplied in a blister pack or dosette box if that would help?
- Will the person need help to take them: a reminder (prompting) or someone to give them (administering)?

- Has a referral been made to the NHS Discharge Medicines Service, so the community pharmacy knows about the changes?
- Will a copy of the medicines list go to the GP and to any care provider?

Questions for the discharge team or social worker

- Which discharge pathway is planned (0, 1, 2 or 3), and what does it mean for us?
- What support has been arranged? How many visits a day, at what times, and who provides them?
- When does the support start, and will it be in place on the day of discharge?
- **Who is paying for each part of this support, from when, and until when? Can we have that in writing?**
- What happens when any free period ends, and how much notice will we get?
- When and where will longer-term needs be assessed?
- Should the person be screened for NHS Continuing Healthcare, now or after discharge?
- Can the main family carer have a carer's assessment?
- Who is our named contact, and what is their direct number?
- What happens if the support is not ready on the day?

Questions about equipment and the home

Occupational therapists and physiotherapists can answer most of these.

- What equipment is needed (for example a frame, commode, raised toilet seat, bed rails or a hospital bed), and when will it be delivered?
- Has anyone checked the home, or does a home visit need to happen first?
- Can the person manage the stairs, or should a bed be set up downstairs?
- Would a key safe, a falls alarm or a pendant alarm help?
- Who do we contact if equipment does not arrive or is not working?

Questions for the GP after discharge

- Have you received the discharge summary? Is anything unclear?
- Does the person need a medication review now that their medicines have changed?
- Is a referral needed to district nurses, community therapists or a specialist team?

- Should we plan ahead for future care, for example an advance care plan or a ReSPECT form?
- If needs are complex or getting worse, should an NHS Continuing Healthcare checklist be completed?
- Would you support a benefit claim, such as Attendance Allowance, if asked?

Questions for a care provider

If you are arranging private care, or the council is commissioning a provider for you:

- Are you registered with the Care Quality Commission (CQC), and what is your current rating?
- When can you start, and can you work to the expected discharge date?
- Will the same carers come each time? How are carers matched to the person?
- Can your carers help with the specific needs: medicines, moving and handling, catheter or stoma care, pressure area care, dementia?
- How will you keep the family informed, and who do we call out of hours?
- What does the care cost, what is included, and what is the notice period?
- For live-in care: what are the carer's breaks, who covers them, and what happens when the carer has time off?

Our guide on how to choose a care provider covers this in more depth.

If the person cannot decide for themselves

- Has the person's capacity been assessed for this specific decision?
- Who is the decision-maker, and how are the person's wishes being taken into account?
- Is there a Lasting Power of Attorney for health and welfare, and has the attorney been consulted?
- If there is no family or friend to consult, has an independent advocate (IMCA) been appointed?

See mental capacity and best interests for how these decisions should be made.

If you are worried about the plan

It is right to speak up. Say clearly, and in writing if you can, what worries you and why: for example, the person cannot climb the stairs, lives alone, or has fallen at night. Ask for the plan to be reviewed. The hospital's Patient Advice and Liaison Service (PALS) can help, and an advocate can support someone who finds it hard to be heard. If a regulated care service is unsafe, you can also tell the CQC.

Words you can use

Copy and adapt these for an email or a conversation with the ward manager, discharge coordinator or social worker.

Requesting an NHS Continuing Healthcare checklist:

> "We believe [name]'s needs may be primarily health needs: [for example, frequent falls, swallowing difficulties, pressure sores, unpredictable behaviour]. Please could an NHS Continuing Healthcare checklist be completed. If the team feels it should be done after discharge, please confirm in writing when, where and by whom, and what support will be in place until then."

Raising a concern about the discharge plan:

> "We are concerned that the discharge plan for [name], due to leave on [date], is not safe because [reasons]. Please could the plan be reviewed before discharge and our concerns recorded in the notes. We would like to speak to the consultant or the discharge coordinator today."

Confirming arrangements:

> "To make sure we have understood, please could you confirm by email the support that has been arranged, who is providing and paying for it, the start date, any end date for free support, and our named contact."

Day of discharge checklist

- [ ] Medicines collected, with a written list of changes
- [ ] Discharge letter or summary, and a copy for any care provider
- [ ] Equipment delivered, or a confirmed delivery time
- [ ] Transport arranged, with warm clothes, shoes and keys
- [ ] Heating on, food and drinks in the house
- [ ] First care visit confirmed, with the time and the provider's number
- [ ] Follow-up appointments and the named contact written down
- [ ] Someone to check in on the first evening

Useful numbers

- **The named contact** on the discharge paperwork, for problems with the plan or support.
- **The GP surgery**, for medicines and new symptoms.
- **NHS 111**, day or night, for urgent health advice.
- **The council's out-of-hours emergency duty team**, for urgent social care problems.
- **999**, in an emergency.

What to do next

1. Choose the questions that fit your situation and start asking in the first days of the admission.
2. Keep a notebook of names, dates and answers.
3. Ask for funding arrangements and end dates in writing.
4. Check medicines, equipment and transport a day or two before the expected date.
5. On the first day home, check that everything agreed has actually happened, and ring the named contact if not.

How we can help

Since 2014 we have provided Discharge to Assess care, so we know how much depends on getting these answers early. Live-in care is our main service, available anywhere in England from £1,550 a week, and across Oxfordshire we also provide

home care visits, waking nights and sleep-ins. Our free initial assessment includes talking with you, your family and the hospital team, and we will gladly answer the care provider questions above. Call us on 01865 715780.

Common questions

When should we start asking about discharge?
As early as possible, ideally in the first day or two after admission. National guidance says discharge planning should begin on admission, and that an estimated discharge date should be set within 48 hours of an emergency admission. Asking early gives you time to arrange equipment, care and transport, and to raise any worries while there is still time to change the plan, rather than on the morning the person is due to leave.

Do families have a right to be involved in discharge planning?
The patient decides who is involved, as long as they have capacity to make that decision. Since July 2022, NHS hospital trusts have had a legal duty to involve patients and their unpaid carers, including young carers, in discharge planning as early as possible. If the person lacks capacity, the team must consult family and others close to them, and any attorney under a health and welfare Lasting Power of Attorney.

What should we do if the care does not arrive on the first day home?
Ring the contact number on the discharge paperwork or the named case manager straight away. If it is out of hours, contact the council's emergency duty team for social care problems, or NHS 111 for health concerns, and 999 in an emergency. National guidance says anyone needing formal support should have a safety and welfare check on the day of discharge, so a missing visit should be treated as urgent.

Who should we complain to about an unsafe discharge?

Start with the ward manager or discharge team and explain your concerns in writing. The hospital's Patient Advice and Liaison Service (PALS) can often sort problems out quickly. If that does not work, make a formal complaint to the NHS trust, and if you are still unhappy, to the Public Service Ombudsman (formerly the Parliamentary and Health Service Ombudsman). For problems with council-arranged care, use the council's complaints procedure and then the Local Government and Social Care Ombudsman.

Should we get the answers in writing?

Yes, especially about funding. Ask for written confirmation of what support has been arranged, who is paying, the date any free period ends, and the contact details of the person responsible. Keep a notebook of conversations with names, dates and what was agreed. It makes it much easier to follow up, avoids misunderstandings about charges, and helps if you ever need to challenge a decision.

Sources and further information

- GOV.UK: Hospital discharge and community support guidance
- NHS: Planning to leave hospital
- NHS England: NHS Discharge Medicines Service
- GOV.UK: National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care
- NICE NG27: Transition between inpatient hospital settings and community or care home settings
- CQC: Give feedback on care

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CHOOSING LIVE-IN CARE

How to choose a care provider: checklist and questions to ask

A practical checklist for choosing a home care or live-in care provider in England: the questions to ask about training, continuity, out-of-hours support, care plans, reviews, complaints, prices and notice, the red flags to watch for, and how to use CQC reports and reviews.

Read the guide →

All guides in the information centre Check what help you could get

This page online: **www.dayandnightcare.co.uk/guides/questions-to-ask-before-hospital-discharge/**

Benefits during a hospital stay: the 28-day rules explained

Last updated 30 October 2026; sources last checked 30 October 2026.

IN BRIEF

Attendance Allowance, PIP and Disability Living Allowance carry on for the first 28 days of an NHS hospital stay and are then suspended until the person comes home. Separate stays 28 days or less apart are added together. Carer's Allowance usually stops when the cared-for person's disability benefit stops, while the State Pension is not affected. Telling DWP about both the admission and the discharge date avoids overpayments and gets payments restarted quickly.



IN THIS GUIDE

1. At a glance
2. How the 28 days are counted
3. Exceptions
4. Carer's Allowance when the person cared for is in hospital
5. Pension Credit, State Pension and housing help
6. How to tell DWP
7. When the person comes home
8. Your hospital benefits checklist
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When someone goes into hospital, money is rarely the first worry. But some benefits change after a few weeks, and telling the Department for Work and Pensions (DWP) at the right moments avoids overpayments that have to be paid back. This guide covers England; in Scotland, most disability and carer benefits are now paid by Social Security Scotland under its own rules.

At a glance

Benefit	During an NHS hospital stay	Who to tell
Attendance Allowance	Paid for the first 28 days, then suspended until discharge	Attendance Allowance helpline
PIP (both parts)	Paid for the first 28 days, then suspended until discharge	PIP enquiry line
Disability Living Allowance (adults)	Care and mobility both paid for 28 days, then suspended	DLA helpline
Carer's Allowance	Usually stops when the cared-for person's benefit stops	Carer's Allowance Unit
State Pension	Not affected	No need, unless Pension Credit is paid too
Pension Credit	Continues; extra amounts linked to other benefits can change	Pension Service
Housing Benefit	Usually continues for up to 52 weeks if the person means to return home	The council

How the 28 days are counted

- **The day of admission and the day of discharge do not count.** The count starts the day after the person goes in.
- **Stays 28 days or less apart are added together.** If someone comes home and goes back in within 28 days, the days from both stays count towards the same 28.
- **Some care home days count too** (see the questions below on respite). For PIP, a publicly funded care home stops only the daily living part after 28 days; a hospital stay stops both parts.
- **Payment restarts from the day the person comes home.** If they come home for part of a day, or for weekend leave during a long stay, tell DWP: benefit can be paid for days at home.

Example: Margaret goes into hospital on 1 March and comes home on 20 March: 18 days count (2 to 19 March). She goes back in on 5 April, less than four weeks later, so the stays link. Her Attendance Allowance continues for the first 10 days of the second stay (6 to 15 April), making 28 in total, and is suspended from 16 April until the day she comes home.

Exceptions

- **Independent hospices:** if someone is terminally ill and staying in a hospice that is not an NHS hospital, their Attendance Allowance, PIP or DLA can continue once DWP has been told they are terminally ill.
- **Private patients:** the rule applies to people treated free of charge by the NHS, so someone paying privately for their hospital stay is not normally affected. Tell DWP how the stay is being paid for.
- **Children:** for PIP and DLA, the 28-day rule does not apply if the person was under 18 when the stay began.

Carer's Allowance when the person cared for is in hospital

Carer's Allowance depends on the person cared for still receiving their own disability benefit. So when their Attendance Allowance, PIP or DLA is suspended after 28 days in hospital (or sooner, if earlier stays link), the carer's Carer's Allowance usually stops too. When the person comes home and their benefit restarts, contact the Carer's Allowance Unit to get Carer's Allowance going again.

GOV.UK says you must tell DWP if you temporarily stop caring and either of you will be in hospital, a nursing home or respite care for more than 12 weeks, or if you stop caring for more than 28 days for any other reason. Carers UK advises letting the Carer's Allowance Unit know about planned hospital stays and keeping a record of the dates.

If Carer's Allowance stops, a carer who gets the carer addition in Pension Credit keeps it for a further eight weeks.

Pension Credit, State Pension and housing help

- **State Pension** is not reduced by a hospital stay.

- **Pension Credit** usually continues, but the severe disability addition depends on the person getting Attendance Allowance, PIP daily living or a similar benefit. When that benefit is suspended, the addition can stop too (couples who both qualify have some protection). Report the stay to the Pension Service.
- **Housing Benefit** for people over State Pension age can continue for up to 52 weeks in hospital if the person intends to return home, the home is not let, and the stay is unlikely to last longer than that. Tell the council's benefits team, which also deals with Council Tax Reduction.
- **Cold Weather Payments:** GOV.UK asks people to tell the Pension Service or Jobcentre Plus about a hospital stay, as it could affect payments. Universal Credit claimants should add a note to their online journal.

How to tell DWP

Who to call	Number	Hours
Attendance Allowance helpline	0800 731 0122	Monday to Friday, 8am to 6pm
PIP enquiry line	0800 121 4433	Monday to Friday, 9am to 5pm
DLA helpline (born after 8 April 1948)	0800 121 4600	Monday to Friday, 9am to 5pm
DLA helpline (born on or before 8 April 1948)	0800 731 0122	Monday to Friday, 8am to 6pm
Carer's Allowance Unit	0800 731 0297	Monday to Friday, 8am to 6pm
Pension Service	0800 731 0469	Monday to Friday, 8am to 6pm

Calls are free. For Relay UK, dial 18001 before the number. Someone else can call on the person's behalf if the person is with them, or as their appointee or attorney.

Have ready: the person's National Insurance number, the hospital's name and address, the admission date, any earlier stays in the last few months, and (later) the discharge date.

What to say: "I'm calling to report that my mother, [name], National Insurance number [number], was admitted to [hospital] on [date]. She was also in hospital from [date] to [date]. Please note the dates on her Attendance Allowance claim, and tell me when payments will be suspended. I'll call again with her discharge date."

When the person comes home

1. **Call DWP with the discharge date,** so suspended benefits restart from that day.
2. **Report a change in needs.** If the person now needs more help, particularly at night, they may qualify for a higher rate of Attendance Allowance or PIP.
3. **Tell the Carer's Allowance Unit** that caring has restarted.
4. **Plan the support at home** before discharge. See leaving hospital: what to expect and questions to ask before hospital discharge.

Attendance Allowance and PIP continue as normal for someone cared for at home, including with live-in care after a hospital stay, and can be spent towards the cost of care.

Your hospital benefits checklist

- [ ] Admission date written down, and any stays in the last 28 days
- [ ] DWP told about the admission (each benefit separately)
- [ ] Carer's Allowance Unit told, if someone gets Carer's Allowance
- [ ] Pension Service and council told, if Pension Credit or Housing Benefit is paid
- [ ] Discharge date reported, so payments restart
- [ ] Change in care needs reported after discharge

What to do next

1. Make a note of the admission date today.
2. Call each helpline that pays the person a benefit.
3. Plan the discharge early, including care at home.
4. Report the discharge date as soon as it is confirmed.

How we can help

Day and Nightcare is a CQC-registered home care provider, rated Good. Since 2014 we have provided Discharge to Assess care, and for several years we ran Oxfordshire's Urgent Response service, so we know how much a well-planned discharge matters. Our fully managed live-in care is available anywhere in England from £1,550 a week, and we offer home care visits and waking nights across Oxfordshire, and 24-hour care with carers working in shifts anywhere in England. For a free initial assessment, call 01865 715780.

Common questions

Mum went into hospital before her Attendance Allowance claim was decided. Should we carry on?

Yes. You can claim while someone is in hospital, and give the hospital's details on the form. If the award starts while she is still an inpatient, it is usually not paid until she comes home, but having the decision in place means payment can begin from the day she leaves. If she is terminally ill and in an independent hospice, payment can continue there once DWP has been told. Ask a doctor about the SR1 form for faster claims at the end of life.

I am the carer and I need an operation. What happens to my Carer's Allowance?

It can usually continue for up to 12 weeks while you are in hospital, provided you had been caring for at least 35 hours a week in at least 14 of the last 26 weeks, and as long as the person you care for keeps getting their own disability benefit. Tell the Carer's Allowance Unit on 0800 731 0297. Arrange cover for the person you care for before you go in: their council can assess them for replacement care.

Do we have to report a short stay of only a few days?

Yes, it is safest to report every hospital admission. GOV.UK lists going into hospital as a change that must be reported for Attendance Allowance, PIP and Pension Credit, and for Disability Living Allowance any stay of more than two days. A short stay will not stop payments, but DWP needs the dates in case the person goes back in within 28 days, when the stays are added together. Keep a note of each admission and discharge date.

What happens if we forget to tell DWP about a long stay?

The benefit will probably have been overpaid, and DWP can ask for it back, for example by taking deductions from future benefit payments. GOV.UK also warns that people who do not report a change can face a penalty or be taken to court. Phone the helpline as soon as you realise, give the exact dates, and keep a note of who you spoke to and when. If a repayment is requested, ask for a plan you can afford.

Does Attendance Allowance stop if Dad goes to a care home for respite after hospital?

It depends on who pays. Days in a care home funded by the council or the NHS count towards the same 28 days as hospital days, and the two are added together if the gap between them is 28 days or less. If the family pays the full care home fee privately, Attendance Allowance continues as normal. It also continues for anyone cared for at home, including with live-in care, however the home care is funded.

Sources and further information

- legislation.gov.uk: Social Security (Attendance Allowance) Regulations 1991, regulations 6 and 8
- legislation.gov.uk: Social Security (Personal Independence Payment) Regulations 2013, Part 7
- GOV.UK: Attendance Allowance, report a change in circumstances
- GOV.UK: Carer's Allowance, if you temporarily stop providing care
- Carers UK: Carer's Allowance and breaks in care
- Citizens Advice: Attendance Allowance, change of circumstances
- GOV.UK: Disability benefits helplines
- legislation.gov.uk: Housing Benefit (State Pension Credit) Regulations 2006, regulation 7

Read next

PAYING FOR CARE AND REDUCING THE COST

Attendance Allowance: rates, who qualifies and how to claim

Attendance Allowance pays £76.70 or £114.60 a week in 2026/27 to people over State Pension age who need help with personal care or supervision. Who qualifies, how to claim step by step, example wording for the form, end-of-life claims and a letter to challenge a decision.

Read the guide →

PAYING FOR CARE AND REDUCING THE COST

Personal Independence Payment (PIP): a guide for families

PIP helps people aged 16 to State Pension age with the extra costs of a long-term condition or disability. The 2026/27 rates, how the points work, how to claim step by step, example wording for the form, end-of-life rules and PIP at State Pension age.

Read the guide →

PAYING FOR CARE AND REDUCING THE COST

Carer's Allowance: who can claim and how it affects other benefits

Carer's Allowance pays £86.45 a week in 2026/27 to people who care for someone at least 35 hours a week and earn £204 a week or less. Who qualifies, the effect on the cared-for person's benefits, Carer's Credit, underlying entitlement and how to claim step by step.

Read the guide →

All guides in the information centre Check what help you could get

This page online: **www.dayandnightcare.co.uk/guides/benefits-during-a-hospital-stay/**

What to do if a hospital discharge feels unsafe

Last updated 30 October 2026; sources last checked 30 October 2026.

IN BRIEF

Patients and their unpaid carers have the right to be involved in discharge planning and to have concerns heard and recorded, but nobody has the right to stay in a hospital bed they no longer need. If a plan feels unsafe, say so early and in writing, explain exactly what could go wrong at home, and ask for the plan to be reviewed before the person leaves. If that does not work, escalate step by step: the nurse in charge, the discharge team, the consultant, then PALS and a formal complaint.



IN THIS GUIDE

1. Your rights when someone is leaving hospital
2. Signs a discharge plan may not be safe
3. Who to speak to, and in what order
4. Words you can use on the ward
5. An email you can copy
6. Keep a simple record
7. If the discharge has already happened and it is not working
8. What can make a discharge safer
9. What to do next
10. How we can help
11. Common questions
12. Sources and further information

Your rights when someone is leaving hospital

Hospitals in England follow the government's statutory Hospital Discharge and Community Support Guidance. It gives patients and families real rights, and it also sets limits. Knowing both helps you raise a concern in a way that gets results.

What the hospital should do:

- **Involve you early.** NHS trusts have a legal duty, introduced by the Health and Care Act 2022, to involve patients and their unpaid carers, including young carers, in discharge planning as soon as is feasible, where appropriate.
- **Plan for the person's needs.** Their immediate recovery needs should be worked out before they leave, with a plan to meet them. That includes practical matters such as equipment, adaptations and whether the home is suitable.
- **Check on them at home.** Anyone who needs formal care and support after discharge should have an initial safety and welfare check on the day they go home.
- **Explain what happens next.** Discharge information should cover the person's medicines and how to raise concerns if something goes wrong.
- **Respect the person's choices.** Someone with mental capacity makes their own decisions about the care they accept. If they lack capacity for the decision, it must be made in their best interests, with the family consulted.
- **Not depend on family who cannot care.** If a relative is unwilling or unable to provide the care needed, the NHS, council and care providers should work together to arrange it.
- **Avoid big decisions in a crisis.** People should not have to decide about long-term care, such as a permanent care home, while in an acute hospital bed.

The limits:

- Nobody has a right to stay in a hospital bed they no longer clinically need, including to wait for a preferred care home or provider. A suitable short-term alternative should be offered instead.
- If every short-term option is turned down, the person can still be discharged to an alternative that meets their recovery needs.

So the strongest concern is rarely "they should stay in hospital". It is "this part of the plan is missing, and this is what could go wrong".

Signs a discharge plan may not be safe

One tick does not always mean the plan is wrong, but each is worth raising.

- [ ] They cannot get to the toilet, in and out of bed or up the stairs safely, and nobody is planned to help.

- [ ] Equipment the therapists recommended, such as a commode, frame or hospital bed, has not been delivered.
- [ ] Care visits are “being arranged” with no provider, start time or named contact.
- [ ] They have new confusion, are barely eating or drinking, or have a pressure sore nobody has explained.
- [ ] Their medicines have changed and nobody has explained the changes to whoever will manage them.
- [ ] They live alone, have fallen at night and have no way to call for help.
- [ ] The plan assumes a relative will provide care they have not agreed to, or cannot give.
- [ ] They will arrive late in the evening to a cold, empty home with no food or heating.
- [ ] Nobody in the family has been told the discharge date.

Who to speak to, and in what order

1. **The nurse in charge of the ward.** Explain the specific worry and ask for it to be recorded in the notes.
2. **The discharge coordinator, social worker or care transfer hub case manager.** They arrange the support. Ask what is confirmed, what is outstanding and who is paying.
3. **The consultant or a senior doctor.** Ask to discuss the plan. For complex needs, ask for a meeting with the therapists and social worker too.
4. **The ward manager or matron**, if answers are not coming.
5. **The Patient Advice and Liaison Service (PALS).** Free, confidential help, found in most hospitals, to resolve problems informally. If discharge is imminent, say it is urgent. The ward or hospital switchboard has the number.
6. **A formal complaint**, either to the hospital trust or to the integrated care board (ICB) that commissions the service, but not both.
7. **The ombudsman.** For the NHS, the Public Service Ombudsman, the new name since 1 October 2026 for the Parliamentary and Health Service Ombudsman (0345 015 4033, Monday to Thursday 9am to 4pm, Friday 8.30am to 12pm). For councils and care providers, the Local Government and Social Care Ombudsman (0300 061 0614).

Alongside these:

- **If someone is at risk of harm**, you can raise a safeguarding concern with the council's adult social care team.
- **If a regulated care service is unsafe**, tell the Care Quality Commission (03000 616161, Monday to Friday, 8.30am to 5.30pm).
- **If you need support to speak up**, free independent NHS complaints advocacy is available at any stage. Search for "NHS complaints advocacy" and your council area.

Words you can use on the ward

Calm, specific and written down works best. Adapt these:

- **Stating the risk:** "Mum has fallen twice at night going to the toilet. The plan has no help overnight and the commode has not arrived. What will happen at 2am?"
- **Asking for a record:** "Please could you note our concerns in her records today, and tell us who will review the plan and when?"
- **When family cannot provide care:** "I work full time and live an hour away. I can visit at weekends but I cannot give daily care. Please do not plan the discharge on the basis that I can."
- **Asking for a short wait or an alternative:** "We are not asking for her to stay longer than she needs to. We are asking for the discharge to wait until the care and equipment are confirmed, or for a short-term alternative to be offered."
- **About capacity:** "Dad seems more confused than before he came in. Has his capacity to decide about going home been assessed, and how were his views and ours taken into account?"

An email you can copy

Send it to the ward manager and discharge team, and copy in PALS if discharge is close.

> **Subject:** Urgent: concern about the discharge plan for [full name], [ward], NHS number [number]
>
> Dear [ward manager or discharge coordinator],

> I am the [relationship] of [name], who is on [ward] and expected to go home on [date]. We want [name] to go home when it is safe, but we are worried the current plan is not safe because:
>
> 1. [for example: no help is planned at night, and she has fallen twice at night]
> 2. [for example: the commode and raised toilet seat have not been delivered]
> 3. [for example: I cannot provide daily care, as I work full time]
>
> Please could you record these concerns in [name]'s notes, review the plan before discharge, and confirm in writing what support will be in place, who is providing and paying for it, when it starts, and the name and number of our contact.
>
> [Name] has agreed to me raising this. [Or: I hold a registered Lasting Power of Attorney for health and welfare.]
>
> I would be grateful for a reply today on [phone number].
>
> Yours sincerely, [your name]

Keep a simple record

- a dated note of each conversation: who, when, and what was said or agreed
- the expected discharge date and the planned discharge pathway
- copies of the discharge letter and medicines list
- the name and direct number of your contact
- emails sent and replies received

This helps if you need to complain later, and it helps the next professional understand what has happened.

If the discharge has already happened and it is not working

- Ring the named contact or care transfer hub on the discharge paperwork if care does not arrive or the plan is failing.
- Ring the GP surgery about medicines or new symptoms, or NHS 111 for urgent advice day or night.

- At nights and weekends, the council's out-of-hours emergency duty team deals with urgent social care problems.
- Call 999 in an emergency.

What can make a discharge safer

Sometimes the answer is not more time in hospital but different support while the person recovers. The four discharge pathways are explained in leaving hospital: what to expect.

- **Reablement or intermediate care**, free for up to six weeks. See reablement and intermediate care.
- **A short stay in a community bed** (pathway 2) for rehabilitation before going home.
- **A voluntary "home from hospital" service** for shopping, settling in and check-in calls.
- **Equipment delivered before the day**, and a bed downstairs if stairs are a problem.
- **Privately arranged care**, such as extra visits, waking nights or live-in care. Tell the discharge team early so it is written into the plan.

If the person may have a primary health need, ask whether NHS Continuing Healthcare should be considered.

What to do next

1. Write down exactly what worries you and what could go wrong at home.
2. Raise it today with the nurse in charge and ask for it to be recorded.
3. Ask the discharge coordinator what is confirmed, what is outstanding and who is paying.
4. If nothing changes, send the email above and contact PALS.
5. Keep a dated record of every conversation.

How we can help

Since 2014 we have provided Discharge to Assess care, and for several years we ran Oxfordshire's Urgent Response service, so we understand how hospital discharges work and where they can go wrong. If more support at home would

make a discharge safer, we provide live-in care anywhere in England, from £1,550 a week, and home care visits, waking nights and sleep-ins across Oxfordshire. Call us on 01865 715780 to arrange a free initial assessment.

Common questions

Can the hospital discharge someone against the family's wishes?
Yes, in some situations. If the patient has mental capacity and wants to go home, their decision comes first, even if the family or professionals disagree; the team should then help them manage the risks. If they lack capacity for the decision, it must be made in their best interests and the family must be consulted. What should not happen is a discharge where the support the hospital has assessed as needed is not in place. If you believe that is happening, raise it in writing straight away.

Do I have to look after my parent when they come home?
No. A family member cannot be made to provide care. National discharge guidance says that if a relative or unpaid carer is unwilling or unable to provide the care needed, the NHS, the council and care providers should work together to arrange it. Tell the discharge team plainly what you can and cannot do, for example that you can visit at weekends but work full time, and ask for a carer's assessment if you will be helping.

Can we refuse the short-term care home place the hospital offers?
You can say no, but the person cannot stay in hospital to wait for a different option. National guidance says that if someone turns down the short-term options offered, they should be discharged to another suitable alternative for their recovery. Ask why the place is being offered, how long it is for, who pays and what would be needed for a safe discharge home instead. A short-term placement is for recovery and assessment; it should not be treated as a permanent decision.

How long do we have to complain about a hospital discharge?

Normally 12 months from the events, or from when you became aware of the problem. The NHS can extend this if there is a good reason and a fair investigation is still possible. You should receive an acknowledgement within 3 working days. If you are still unhappy after the final response, you can ask the Public Service Ombudsman (called the Parliamentary and Health Service Ombudsman until 1 October 2026; 0345 015 4033) to look at it. Free NHS complaints advocacy can help you write the complaint.

What if the person is readmitted soon after going home?

Get help in the usual way first: NHS 111, the GP, or 999 in an emergency. A readmission does not by itself mean the discharge was wrong, but if you believe it happened because the plan was unsafe or not followed, write down what happened while it is fresh. Tell the new ward, so the next discharge plan takes it into account, and raise it with PALS or as a complaint if you want it looked into.

Sources and further information

- GOV.UK: Hospital discharge and community support guidance
- NHS England: Feedback and complaints
- Public Service Ombudsman (formerly the Parliamentary and Health Service Ombudsman): Contact us
- CQC: Contact us
- legislation.gov.uk: Mental Capacity Act 2005

Read next

LEAVING HOSPITAL AND RECOVERY

Leaving hospital: what to expect and how to prepare

How hospital discharge works in England today: the discharge pathways, who the discharge team are, timing, transport, medicines and equipment, what families can do, and how to arrange private or live-in care quickly.

Read the guide →

LEAVING HOSPITAL AND RECOVERY

Questions to ask before hospital discharge: a checklist

A practical checklist of questions to ask the ward, the discharge team, the pharmacist, the GP and the care provider before someone leaves hospital, covering the plan, medicines, equipment, funding, follow-up and what to do if something goes wrong.

Read the guide →

LEAVING HOSPITAL AND RECOVERY

Discharge to Assess (D2A) explained for families

What Discharge to Assess (D2A) means in England: the four pathways, which care is free and for how long, what happens when the D2A period ends, assessments for council funding and NHS Continuing Healthcare, and how to plan ahead.

Read the guide →

All guides in the information centre Check what help you could get

This page online: **www.dayandnightcare.co.uk/guides/what-to-do-if-a-discharge-feels-unsafe/**

Care after surgery at home: hip, knee and other operations

Last updated 30 October 2026; sources last checked 30 October 2026.

IN BRIEF

Most people go home within a few days of a planned hip or knee replacement, and the first few weeks at home are when help matters most: getting in and out of bed, washing, dressing, meals and keeping up the exercises. Plan before the operation: ask about equipment and free reablement, decide who will help in the first weeks, especially at night, and arrange home care or live-in care if family cannot be there. Your own surgical team's instructions always take priority over general timelines.



IN THIS GUIDE

1. Plan before the operation
2. Typical recovery timelines
3. Looking after a new hip or knee
4. After a broken hip or emergency surgery
5. Other operations
6. The help most people need in the first weeks
7. Equipment that helps
8. Free help: reablement and intermediate care
9. Convalescent care: the options
10. How live-in care helps after surgery
11. Warning signs after surgery
12. What to do next
13. How we can help
14. Common questions
15. Sources and further information

Plan before the operation

For a planned operation, the best time to arrange help at home is before you go in. Most people leave hospital within a few days, so there is little time to organise things afterwards.

Questions to ask at the pre-admission clinic:

- How long am I likely to be in hospital?
- What will I be able to do for myself when I get home, and for how long will I need help?
- Will an occupational therapist assess what equipment I need, and when will it arrive?
- Will I be offered reablement or other support at home, and who arranges it?
- Will I go home with blood-thinning medicine, injections or compression stockings, and who will help with them?
- When will the stitches or clips come out, and where?
- Who do I call if I am worried after I get home?

Getting the home ready:

- [ ] Move everyday things to between waist and shoulder height.
- [ ] Clear trip hazards: loose rugs, trailing wires and clutter on the stairs.
- [ ] Fill the freezer with ready meals and stock up on easy food and drinks.
- [ ] Make sure there is a firm, high chair with arms.
- [ ] If stairs will be hard, plan a bed downstairs and access to a toilet or commode.
- [ ] Arrange lifts: after a hip replacement you will not be able to drive for at least six weeks.
- [ ] Decide who will be with you, especially for the first nights.
- [ ] Ask your energy supplier to add you to its Priority Services Register while you recover; people recovering after a hospital stay can join.

Typical recovery timelines

Recovery varies with age, general health and the operation, and your surgical team's instructions always come first. As a general guide, the NHS says:

Milestone	Hip replacement	Knee replacement
Usual hospital stay	about 1 to 3 days	about 1 to 4 days
Stitches or clips removed	after about 10 days	after about 10 days

Milestone	Hip replacement	Knee replacement
Follow-up appointment	around 6 to 12 weeks	about 6 weeks
Driving	at least 6 weeks, if your doctor agrees	at least 6 weeks for a total knee (3 weeks for a partial)
Return to work	usually about 6 weeks	usually 6 to 12 weeks
Full recovery	several months	several months or longer

The first two weeks are usually the hardest: pain, swelling, tiredness and getting used to walking aids. Most people start with crutches or a walking frame and move to a single stick as confidence grows. After a knee replacement, the NHS suggests trying to walk without an aid after about six weeks if you feel ready.

Looking after a new hip or knee

After a hip replacement, the NHS advises:

- do not cross your legs
- do not bend the hip more than 90 degrees (a right angle), or bend down to touch your feet or ankles
- do not sit in low chairs, on low toilets or in chairs without arms
- walk a little every day, as far as is comfortable, and keep up the exercises
- avoid sitting still for long periods, which helps with swelling

After a knee replacement, the NHS advises:

- avoid twisting the knee, and do not cross your legs for the first six weeks
- do not sleep with a pillow under the knee, or kneel until your doctor says it is safe
- avoid heavy household tasks, such as vacuuming or carrying shopping, for three months
- wear compression stockings as advised, usually at all times except for washing

After a broken hip or emergency surgery

Recovery after a broken hip (hip fracture) is usually slower than after a planned replacement. The person is often older, may have fallen at home, and may already have been frail. Sudden confusion (delirium) is common in hospital and can take time to settle. More help is usually needed for longer, and preventing another fall becomes a priority: see falls prevention and frailty in later life.

After any emergency operation there is no time to prepare, so the plan is made on the ward. Our questions to ask before hospital discharge help.

Other operations

The same principles apply after heart, bowel, cancer or other major surgery. Ask the team for written instructions about:

- lifting and driving, which are often restricted for several weeks
- wound care, dressings and when you can shower
- pain relief, and how to prevent constipation from strong painkillers
- eating well when appetite is poor
- how much to do each day: tiredness after major surgery can last for weeks

The help most people need in the first weeks

- getting in and out of bed, chairs and the shower safely
- washing and dressing, especially feet, socks and shoes
- preparing meals and drinks, and carrying them, which is hard with crutches
- taking painkillers on time, and any blood-thinning medicine
- encouragement with the exercises, which make a real difference to the result
- keeping an eye on the wound and noticing early warning signs
- company and reassurance, particularly at night

Equipment that helps

An occupational therapist may recommend:

- a raised toilet seat or toilet frame
- a perching stool for the kitchen or bathroom
- chair or bed raisers, and a bed lever

- a long-handled reacher (grabber), a sock aid and a long-handled shoehorn
- a walking frame or crutches, and a kitchen trolley to carry things
- a shower seat or bath board

When someone is assessed as needing them, the council must provide aids, and minor adaptations costing £1,000 or less, free of charge. If you buy your own, ask the therapist which items and heights are right first. See equipment and home adaptations.

Free help: reablement and intermediate care

Ask the ward whether reablement or intermediate care will be offered. It is free for up to six weeks and focuses on helping you do things for yourself again. Not everyone is offered it after planned surgery, and visits are often short, so many people combine it with family help or private care. See reablement and intermediate care.

Convalescent care: the options

- **Family and friends**, if they live nearby and are able. Be realistic about nights and lifting.
- **Home care visits**, for example morning and evening help with washing, dressing and meals.
- **Live-in care**, with a carer living in your home through the first weeks of recovery.
- **A short stay in a care home**, with staff on hand day and night.
- **An intermediate care bed**, if the NHS or council offers one for rehabilitation.

Some private medical insurance policies include help at home after surgery, so check yours. If needs continue beyond the recovery period, ask the council for a care needs assessment.

How live-in care helps after surgery

A live-in carer can be there from the first evening home, helping safely with getting up, washing, dressing and meals, prompting medicines and encouraging the exercises. Having someone in the house at night matters, because getting to the toilet in the dark is a common time for falls. Live-in care works alongside reablement workers, physiotherapists and district nurses. The home needs a spare

bedroom for the carer. If someone needs two people to help them move, or frequent nursing, a different arrangement may suit them better. See care after a hospital stay.

Warning signs after surgery

After a hip or knee replacement, the NHS advises asking for an urgent GP appointment or contacting NHS 111 if there is:

- throbbing or cramping pain in the leg or hip
- a high temperature, or feeling hot, cold or shivery
- oozing or pus from the wound
- redness, tenderness, swelling or pain that is not getting better or is getting worse

Call 999 or go to A&E if there is pain and swelling in the leg with difficulty breathing or chest pain, as this could be a blood clot in the lungs. Do not drive yourself to A&E. Keep this list, and the ward's phone number, by the phone.

What to do next

1. Ask the pre-admission team the questions above.
2. Get the home ready and arrange equipment before the operation.
3. Decide who will help in the first weeks, especially at night.
4. If family cannot cover it, contact care providers before the operation date.
5. Keep the warning signs and the ward's number by the phone.

How we can help

We are a CQC-registered home care provider, rated Good, supporting people at home since 2008. Our live-in care is available anywhere in England, from £1,550 a week, and in Oxfordshire we also offer home care visits, waking nights and sleep-ins. If you are planning an operation, it helps to talk to us before the date, so support is ready when you come home. Call us on 01865 715780 to arrange a free initial assessment.

Common questions

How long will I need help at home after a hip or knee replacement?

Most people need the most help in the first two weeks and some help for around six weeks, but it varies with age, general health and how the operation went. You will not be able to drive for at least six weeks, so lifts and shopping need planning for that long. Many people manage alone sooner, while older or frailer people, or anyone recovering from a broken hip, often need help for longer. Ask your surgical team what to expect in your case.

Is care free after an operation?

Some is. Reablement and intermediate care arranged by the council or NHS are free for up to six weeks, and equipment the council assesses you as needing is lent free. Not everyone is offered reablement after planned surgery, and it does not cover everything. Private home care or live-in care is paid for by you. Attendance Allowance usually will not help with a short recovery, because you must have needed help for at least six months.

Can a live-in carer help with exercises and compression stockings?

A live-in carer can encourage and support the exercises your physiotherapist has set, help you put on and take off compression stockings if this is in your care plan, and help with washing, dressing, meals and getting about safely. They do not replace the physiotherapist, who decides what exercises are right. If you need injections, wound dressings or other nursing tasks, ask the ward who will provide them, as these usually involve district nurses or trained staff.

When can I have a bath or shower after a hip or knee replacement?

Follow your ward's instructions, because they depend on the type of dressing and how the wound is healing. Many people are advised to shower rather than bath at first, and getting in and out of a bath safely is difficult in the early weeks, particularly with hip precautions. A shower seat, bath board or perching stool helps, and having someone in the house the first few times makes it much safer. Ask the occupational therapist before you go home.

What is convalescent care?

Convalescent care is short-term support while someone recovers from an operation, illness or injury, until they can manage on their own again. It can be given at home, through care visits or a live-in carer, or in a care home as a short stay. The aim is recovery and confidence rather than long-term care. It is usually arranged privately, although the NHS or council may offer free reablement or an intermediate care bed for up to six weeks.

Sources and further information

- NHS: Recovering from a hip replacement
- NHS: Complications of a hip replacement
- NHS: Preparing for a hip replacement
- NHS: Recovering from a knee replacement
- NHS: Complications of a knee replacement
- NHS: Care to support recovery after leaving hospital
- legislation.gov.uk: Care and Support (Charging and Assessment of Resources) Regulations 2014, regulation 3
- Ofgem: Join your supplier's Priority Services Register

Read next

LEAVING HOSPITAL AND RECOVERY

Reablement and intermediate care: free help to recover

Reablement and intermediate care help people recover after a hospital stay, a fall or an illness. Find out what is free (up to six weeks), who provides it, how goals are set, how to get it without a hospital stay, and what happens afterwards.

Read the guide →

LIVING SAFELY AND WELL AT HOME

Equipment and home adaptations: what is free and how to get it

How to get equipment and home adaptations for an older or disabled person in England: occupational therapy assessments, free council and NHS equipment, Disabled Facilities Grants of up to £30,000, VAT relief, beds, hoists and stairlifts, and how to buy safely.

Read the guide →

LEAVING HOSPITAL AND RECOVERY

Leaving hospital: what to expect and how to prepare

How hospital discharge works in England today: the discharge pathways, who the discharge team are, timing, transport, medicines and equipment, what families can do, and how to arrange private or live-in care quickly.

Read the guide →

All guides in the information centre Check what help you could get

This page online: **www.dayandnightcare.co.uk/guides/care-after-surgery-at-home/**