LEAVING HOSPITAL AND RECOVERY

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.



IN THIS GUIDE

1. How hospital discharge works in England
2. The four discharge pathways
3. Who is on the discharge team
4. Timing: when will they come home?
5. Documents and information to have ready
6. Getting home: transport and the first day
7. Medicines to take home
8. Equipment and adapting the home
9. What families can do
10. Words you can use
11. Who to call if something goes wrong after discharge
12. Arranging private care quickly
13. Going home with live-in care
14. What to do next
15. How we can help
16. Common questions
17. Sources and further information

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

Talk to our care team: 01865 715780

enquiries@dayandnightcare.co.uk · Out of hours: 07775 686272

Day and Nightcare Live In Limited, 9 Hollow Way, Cowley, Oxford OX4 2NA

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

The latest version of this page: **www.dayandnightcare.co.uk/guides/leaving-hospital-what-to-expect/**

Guide last reviewed 30 October 2026. This PDF was made on 1 November 2026.

Information, not advice: please check anything important with the organisation named.