Who to send it to

The consultant or nurse in charge of the ward, and the discharge coordinator or care transfer hub named on the discharge paperwork. Send a copy to the hospital's Patient Advice and Liaison Service (PALS) and, if social care is involved, to the hospital social work team. Email is quickest; mark it urgent.

The letter

Replace everything in [square brackets], keep a copy, and note the date you sent it.

[Your name]
[Your address]
[Your phone number]
[Your email address]

[Date]

[Name of consultant or nurse in charge], [ward name]
[Discharge coordinator or care transfer hub]
[Hospital name and address, or email addresses]

Copy to: Patient Advice and Liaison Service (PALS), [hospital name]

Dear [name, or Sir or Madam],

URGENT: request to review the discharge plan for [full name], date of birth [date of birth], NHS number [NHS number], [ward name]

I am [name]'s [relationship] [and (his/her) main unpaid carer]. [I hold a registered Lasting Power of Attorney for (his/her) health and welfare, and a copy is enclosed.] I understand that [name] is due to be discharged on [date] to [home / (other destination)], with [describe the planned support, for example: one care visit a day].

I am not asking for [name] to stay in hospital longer than necessary. I am asking for the plan to be reviewed before discharge, because I do not believe it is safe, for these reasons:

- [for example: (he/she) lives alone and has fallen twice at night in the last month]
- [for example: (he/she) currently needs two people to help (him/her) stand, but the plan provides one carer]
- [for example: (he/she) is confused at night and cannot use the alarm]
- [for example: the equipment recommended by the occupational therapist will not be

delivered until (date)]
- [for example: I work full time and cannot provide the care the plan assumes]

Under section 74 of the Care Act 2014, the hospital must take appropriate steps to involve [name] and me, as [his/her] carer, in planning the discharge. Please:

1. arrange a discussion with me and the discharge team before any discharge, and tell me who will lead it;
2. confirm which discharge pathway is planned, what support is included, who will pay for it, and for how long;
3. confirm whether [name]'s needs have been considered for NHS Continuing Healthcare, and whether a Checklist has been completed;
4. [if (name) may lack capacity to decide where to live: tell me how (his/her) capacity has been assessed, and how the best interests decision has been made];
5. refer me for a carer's assessment; and
6. record my concerns in [name]'s notes.

I am happy to discuss suitable short-term alternatives, including [for example: reablement, a short stay in a community bed, or privately arranged live-in care], while longer-term needs are assessed.

Please contact me today on [phone number].

Yours [sincerely / faithfully],

[Your signature]
[Your name]
[Your relationship to the person]

Tips

- Act quickly: email the ward and the discharge team as soon as you hear the plan, then phone to check the email has been seen. Ask for the name and direct number of the person coordinating the discharge.
- Keep to facts about risk: falls, night-time needs, how many people are needed to help, equipment, medicines and who will actually be there.
- Patients do not have a right to stay in a hospital bed to wait for a preferred care option, but a suitable short-term alternative should be offered while they wait. Ask what that alternative is.

- Ask which pathway is planned: home with no new care (pathway 0), home with new support (pathway 1), a short stay in a community bed (pathway 2) or a care home (pathway 3). A first permanent care home placement straight from hospital should happen only in exceptional circumstances.
- Anyone who needs formal care after discharge should get a safety and welfare check on the day they go home. Ask who will do it and when.
- If concerns are not dealt with, contact the hospital's Patient Advice and Liaison Service (PALS), and keep a record of every conversation.

The law behind it

Section 74 of the Care Act 2014 (substituted by section 91 of the Health and Care Act 2022, in force since 1 July 2022): where an NHS trust thinks an adult patient is likely to need care and support after discharge, it must, as soon as is feasible after it starts planning the discharge, take appropriate steps to involve the patient and any unpaid carer. The statutory Hospital Discharge and Community Support Guidance (updated January 2024): planning should start on admission; it is good practice to set an estimated discharge date within 48 hours of an emergency admission and share it with the patient, family and unpaid carers; people should be supported to make informed choices; and anyone who needs formal care should have a safety and welfare check on the day of discharge. If the person lacks capacity to decide, decisions must be made in their best interests under section 4 of the Mental Capacity Act 2005. Regulation 21 of the Standing Rules Regulations 2012: NHS Continuing Healthcare must be considered where it appears there may be a need.

Read more in our guide: Leaving hospital: what to expect and how to prepare.

Other letters

- Asking the council for a care needs assessment
- Asking the council for a carer's assessment
- Asking for the written financial assessment and a disability-related expenditure review
- Asking for a review or reassessment of care and support
- Asking for an NHS Continuing Healthcare Checklist