Factsheet 37w ● December 2023

Hospital discharge arrangements for older people in Wales

Age Cymru Advice

0300 303 44 98

www.agecymru.org.uk

Contents

1 Information about this factsheet

This factsheet explains what you should expect from staff involved in planning and arranging your discharge from hospital.

This includes the processes which should be followed to ensure that people receive appropriate further assistance once they have left hospital – be this on a temporary or ongoing basis. This might include:

- other NHS services; *and/or*
- help from the local authority social services department; *and/or*
- services from other organisations (for example, the charity or voluntary sector).

The factsheet applies to NHS-funded treatment in Wales in an NHS hospital (or other establishment where an NHS-funded service is received).

Note: See section 15 below if the NHS is **not** funding your hospital treatment. For example, there will be different hospital discharge issues to be considered if you are paying for private hospital treatment.

Depending on individual circumstances, you might also find it helpful to read some of the following Age Cymru factsheets on topics such as social care, other NHS services or help to improve your home, which may all potentially play a role in assisting people to recover following discharge from hospital (where relevant, these are referred to within the text, so you will be able to determine whether they are likely to be applicable in your situation):

- 41w – *Social care assessments for older people with care needs in Wales*;
- 6w – *Finding help at home in Wales*;
- 46w – *Paying for care and support at home in Wales*;
- 76w – *Reablement, intermediate care and preventative services in Wales*;
- 24w – *Direct payments for social care services in Wales*;
- 20w – *NHS continuing healthcare and NHS-funded nursing care in Wales*;
- 29w – *Finding care home accommodation in Wales*;
- 10w – *Paying for a permanent care home placement in Wales*;
- 44w – *NHS services in Wales*;
- 67w – *Home improvements and repairs for older people in Wales*; and/or
- 42w – *Obtaining disability equipment and home adaptations in Wales*.

Note: The information given in this factsheet is applicable in Wales. Different rules may apply in England, Northern Ireland and Scotland. Contact Age UK, Age NI and Age Scotland respectively for further information.

1.1 Local Health Boards and local authority social services departments

Both Local Health Boards (LHBs) and local authority social services departments will be mentioned frequently within this factsheet:

- LHBs are responsible for delivering all NHS healthcare services within the geographical area they cover, so health professionals working in particular hospitals will ultimately be employed by the relevant LHB for the area where the hospital is located. NHS 111 Wales (see section 17 for contact details) can tell you which LHB will cover your area. Alternatively, you can obtain further information from the Welsh Government website at:

  www.gov.wales/nhs-wales-health-boards-and-trusts

- Local authority social services departments provide social care services to people in the local (council) area. Sometimes the full title will be used in this factsheet; on other occasions we may just refer to the 'local authority' or 'social services'. Social care services include things like assistance in your own home with personal care, provision of aids and equipment to help with daily living tasks, provision of home adaptations or disability equipment, pre-prepared meals ('meals on wheels'), or care provided in a care home setting.

  Contact details for all the local authorities in Wales can be found via the Welsh Government's website at:

  www.gov.wales/find-your-local-authority

Note: Generally, services provided by the NHS are **free**, whereas those arranged by social services are **means tested**.

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2 Welsh Government / NHS Wales guidance on – or relevant to – hospital discharge

There is a main hospital discharge guidance document – see section 2.2 below.

However, there are also a number of other related and complementary documents that should be used in conjunction with it (and indeed, are often referred to within the hospital discharge guidance).

These are detailed in sections 2.1 to 2.7 which follow and have been used to inform the rest of this factsheet.

You may wish to move straight to section 3 onwards for information on what will – or should – happen in regard to your discharge from hospital (as opposed to an outline of the different guidance documents in the rest of the section below).

2.1 Background information – Welsh Government's 'Six Goals for Urgent and Emergency Care'

Note: In February 2022, the Welsh Government published goals and priorities for Urgent and Emergency Care "to ensure that patients get the right care, in the right place, first time"[1]. A number of the goals are not directly related to situations where you're already in hospital and awaiting discharge, but are more general statements on joined up services and reducing hospital admissions via other services etc.

Goals 5 and 6 can be said to be the most relevant ones in relation to hospital discharge processes.

Further information on 'Six Goals for Urgent and Emergency Care' can be found on the NHS Wales website at:

www.nhs.wales/sa/six-goals-for-urgent-emergency-care

The six goals are as follows:

- **Goal 1: Co-ordination planning and support for populations at greater risk of needing urgent or emergency care**

  "To help prevent future Urgent or Emergency Care presentations, populations at greater risk of needing to access them should expect to receive proactive support through enhanced planning and coordination of their health and social care needs. This should support better outcomes".

- **Goal 2: Signposting people with urgent care needs to the right place, first time**

  "People can access a 24/7 urgent care service via NHS 111 Wales" and where there is an urgent health issue that may result in significant harm if not assessed or treated, a phone consultation through 111 should lead to "signposting to a same day or out-of-hours primary care appointment…referral to an urgent primary care centre" *and/or* arranging for "an arrival time slot at a minor injuries unit or Emergency Department".

[1] 'Six Goals for Urgent and Emergency Care', NHS Wales website: www.nhs.wales/sa/six-goals-for-urgent-emergency-care (last accessed 27 November 2023).

- **Goal 3: Clinically safe alternatives to admission to hospital**
  - People should be able to “access appropriate and safe care close to home, and with as much continuity of care, as possible. Admission for ongoing care to an acute hospital bed should only occur if clinically necessary”.
  - “People who have a clinical need for a hospital-based urgent or emergency face-to-face assessment, diagnostics and/or treatment are always considered for management on an (ambulatory) same day emergency care pathway”.
  - “Older people or those nearing the end of their lives should be assessed quickly ‘at the front door’ or adjacent to the Emergency Department “with decisions on their care acted upon by a multi-agency team. This should include a system that is able to respond to peoples’ specific needs to prevent unwanted or unnecessary admission to hospital, focus on maintaining nutrition and hydration [and] mobility”.
- **Goal 4: Rapid response in physical or mental health crisis**

  After the initial response, when people are ready to move on from the emergency department, there should be “effective arrangements in place to provide continuity of care with the minimum of delay, including returning home with support [or] timely admission to a hospital bed”.
- **Goal 5: Optimal hospital care and discharge practice from the point of admission**
  - There should be “a relentless focus on good discharge practice” in line with the Welsh Government’s **‘Hospital discharge guidance’ (December 2023)** (see section 2.2 below).
  - One of the other resources included under ‘Goal 5’ is the NHS Wales guidance, **‘Delivering optimal outcomes and experience for people in hospital’** (see section 2.3 below).
  - The ‘optimal outcomes’ guidance provides a framework for ‘hospital patient flow’, a part of which are the **‘Discharge to Recover then Assess (D2RA)’ pathways** (see section 2.3 below).

- **Goal 6: Home first approach and reduce the risk of readmission**
  - "People will return home following a hospital stay – or to their local community with additional support if required – at the earliest and safest opportunity to improve their outcomes" and to avoid 'deconditioning'; *or*
  - where people require additional support on discharge, they "should be transferred from hospital onto the appropriate 'discharge to recover then assess pathway' [D2RA] (usually back to their normal place of residence) within 48 hours of the treatment of their acute problem being completed"[2] (also see section 2.2 below for information on **D2RA**).

Note: "Deconditioning is a complex process of physiological change following a period of inactivity, bedrest or sedentary lifestyle. It results in functional losses in areas such as mental status, degree of continence and ability to accomplish activities of daily living"[3] (also see section 3.5 below).

The following are published as part of 'Goal 6':

- **'Step-down to Recover (SD2R): National Minimum Service Guidance'** (see section 2.4 below); *and*
- **'The Management Of Reluctant Discharge / Transfer Of Care To A More Appropriate Care Setting Guidance'** (see section 2.5 below).

2.2 The Welsh Government's 'Hospital discharge guidance' (December 2023)

This new guidance was published on 13 December 2023. It sits within the 'Six Goals for Urgent and Emergency Care', detailed above, and can be accessed via those pages, or through a direct link on the Welsh Government website at:

www.gov.wales/hospital-discharge-arrangements-december-2023

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[2] Ibid

[3] 'Delivering optimal outcomes and experience for people in hospital', NHS Wales.

The guidance is for health and social care staff, plus other organisations that work with them (such as third and independent sector partners) and the Welsh Government advises it should be "considered and utilised alongside" the *'Delivering optimal outcomes and experience for people in hospital'* guidance (see section 2.3 immediately below for further details).

2.3 NHS Wales guidance – 'Delivering optimal outcomes and experience for people in hospital' (including D2RA principles)

A copy of this guidance, published in February 2022, can be accessed on the NHS Wales website at:

www.nhs.wales/sa/six-goals-for-urgent-emergency-care/goal-5/goal-5-resources/delivering-optimal-outcomes-and-experience-for-people-in-hospital-pdf

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Note: The principles and approaches of the Welsh Government's *Discharge to Recover then Assess (D2RA)* – previously found in earlier guidance – have been included **within** the *Delivering optimal outcomes and experience for people in hospital* guidance.

It is made clear in 'optimal outcomes', however, that it "supersedes all previous…D2RA guidance", so we have now taken out reference to the earlier document from this factsheet. D2RA discharge pathways are still mentioned within the factsheet where relevant (with the 'optimal outcomes' guidance as the source).

The 'optimal outcomes' guidance is based around four *'what matters to me'* questions that all professionals (be they health or social services) must be able to answer for the people they care for:

1. **"What do you think is wrong with me"?** (i.e. diagnosis).
2. **"What is going to happen today"?** (i.e. tests, interventions etc).
3. **"What needs to happen to get me home and what can I do to speed things up"?** ("Clinical criteria for discharge and Recovery Plan").
4. **"When can I go home"?** ("estimated date of discharge").

The guidance then emphasises a point that has been integral to a number of previous Welsh Government guidance documents over the last decade or so – that of **'person-centred'** care and treatment:

"Patients, their families and carers must be central to all decision making and their views should always inform the answers to these questions" and they should be "involved in care planning".

The 'optimal outcomes' guidance should be used in regard to "**all adults who have been admitted to a hospital bed at either an acute or community hospital site**".

2.4 NHS Wales guidance – 'Step-down to Recover (SD2R): National Minimum Service Guidance'

'Step-down' services are a further service designed to allow people to leave hospital as soon as possible, whilst still providing support for recovery and rehabilitation. As such, it can be seen as related to already established services such as intermediate care, reablement and rehabilitation – see section 11 below for further information on these and Step-down to Recover services.

The 'Step-down to Recover' guidance has overlaps with the D2RA pathways mentioned in section 2.3 above, in that community step-down to recover services are a potential pathway under D2RA.

The Step-down guidance advises that 'step down' is defined "as a facility for people who are ready to be discharged from hospital but are unable to return to their former home, require further rehab or reablement in a place **other than their usual residence**". The recipient "may require time, support, care and therapeutic interventions to enable them to be rehabilitated and re-abled" (emphasis added).

A copy can be accessed at:

www.nhs.wales/sa/six-goals-for-urgent-emergency-care/goal-6/goal-6-resources/step-down-to-recover-sd2r-national-minimum-service-standards-18-sept-23-e-pdf

2.5 NHS Wales guidance – 'The Management Of Reluctant Discharge / Transfer Of Care To A More Appropriate Care Setting Guidance'

This guidance features as part of the *'Six Goals for Urgent and Emergency Care'* (as part of 'Goal 6'). A copy can be accessed at:

www.nhs.wales/sa/six-goals-for-urgent-emergency-care/goal-6/goal-6-resources/the-management-of-reluctant-discharge-transfer-of-care-to-a-more-appropriate-care-setting-guidance-pdf

The 'Management Of Reluctant Discharge' guidance is for health and social care staff in situations where someone may "decline to participate in either the discharge planning process or the transfer to a more appropriate care setting". It states, however, that it should **only** be used in instances "where all other avenues to ensure care is provided in the most appropriate setting have been considered and not been possible for a range of reasons".

Also see section 14 below for further information on this topic.

2.6 Welsh Government's assessment guidance for people with care and support needs under the Social Services and Well-being (Wales) Act 2014

Hospital discharge guidance should be implemented **alongside** other Welsh Government guidance relevant to care assessments. For example, the Welsh Government's general guidance on the duties and responsibilities of social services departments when carrying out care needs assessments and care planning:

Code of Practice on the exercise of social services functions in relation to Part 3 (Assessing the needs of individuals) of the Social Services and Well-being (Wales) Act 2014

This guidance advises that "local authorities should work with their partner local health boards and NHS trusts to agree arrangements [for] assessments for care and support".

As discussed in section 7 below, assessments of someone's care and support needs may often involve both health and social services staff and, as such, this Code of Practice guidance on assessments (as well as other guidance issued under the *Social Services and Well-being (Wales) Act 2014*) can be relevant in hospital discharge situations.

Further information on the above – and a link to it, plus other accompanying guidance issued under the *Social Services and Well-being (Wales) Act* – can be found in Age Cymru's Factsheet 41w *Social care assessments for older people with care needs in Wales*.

2.7 Welsh Government 'Welsh Health Circular: Implications of the Social Services and Well-being (Wales) Act 2014 for Health Boards and NHS Trusts'

The *Social Services and Well-being (Wales) Act 2014* came into force in April 2016 and created a new legislative framework for social care in Wales. Although, as the name suggests, the Act concerns the operation of social services departments and social care, there are also certain provisions that affect the delivery of NHS services, including hospital discharge. This *Welsh Health Circular* summarises the issues for the NHS from this Act. For example:

- The Act "requires local authorities to plan and provide services designed to prevent, delay or reduce needs for care and support. Health boards are required to **have regard to the importance of achieving these preventative purposes** when exercising their functions".
- "A local authority may carry out a care and support needs assessment for a person at the same time as it, or another body, carries out another assessment". The local authority may "**carry out the other assessment on behalf of, or jointly with, another body**" (for example a Local Health Board).

A copy of the *Welsh Health Circular: Implications of the Social Services and Well-being (Wales) Act 2014 for Health Boards and NHS Trusts (WHC (2016) 028)* can be found on the Welsh Government website at:

www.gov.wales/implications-social-services-and-well-being-act-2014-health-boards-and-trusts-whc2016028

3 Hospital discharge processes

3.1 List of key steps in hospital discharge

The following steps are important for a timely, effective discharge.

As such, health service and/or local authority social services staff should:

- Provide information about the discharge process in a format you can understand and engage with.
- Start discharge planning as soon as possible after they make a diagnosis and agree a treatment plan with you – indeed the most up to date guidance indicates that discharge planning should enter into the consideration of staff from the date of admission (see section 3.2 below). Staff should involve you – and your carer or family as appropriate – at all stages of discharge planning.
- Share an **'estimated discharge date'** with you as soon as possible (also see section 3.2 below); review it regularly and inform you of any change.
- Appoint a named **'Care Coordinator'** (see section 7.2 below) who will have overall responsibility for all stages of the patient's journey through the discharge planning arrangements. There should also be a **'Trusted Assessor'** (see section 7.2).
- Identify your care needs and ability to manage on leaving hospital via a needs assessment. The assessment may involve a wide range of health and/or social care professionals (perceived level of need of the patient will influence who is involved).
- As part of the needs assessment process, consideration should be given as to whether you might be eligible for NHS continuing healthcare (NHS CHC) – see section 12.1 below for further information. NHS CHC is for people with particularly complex and high level needs, so in lots of cases the care needs assessment may be more likely to find you eligible for local authority support, via their social services department.
- As part of the care needs assessment process, staff should consider your views on how best to support you, discuss your options and draw up a care and support plan with you.

- If your partner or carer will provide care and support on discharge, staff should also identify their needs for support and discuss how these might be met. Carers have a right to their own assessment in parallel or sometimes jointly with yours (Age Cymru's Factsheet 41w *Social care assessments for older people with care needs in Wales* has further information on this topic).
- If you are eligible for local authority care and support, staff will arrange an assessment of your ability to pay towards the cost of ongoing social care (though, depending on circumstances, this may occur after you have already left hospital).
- If not eligible for local authority support – perhaps because you only have relatively low level, short term, needs – you should be provided with information and advice about other services (for example those offered by voluntary organisations).
- Staff should ensure all planned arrangements are in place as they should be on the day of discharge – for example, ensuring all equipment, transport and medication have been organised. If you will need assistance to manage medication, arrangements should have been made for this.
- Staff should ensure your discharge plan goes promptly to your GP or any services involved in your further care and support (i.e. if you are to go into a care home, a copy of the plan should be sent there). The discharge plan should include information about your treatment, on-going health needs and medication.
- Once it begins to be delivered, your care plan should be monitored regularly and modifications to it should be put in place as and when necessary:
  - Age Cymru's Factsheet 41w *Social care assessments for older people with care needs in Wales* has further information on monitoring and reviewing care plans where social services are the lead.
  - If your care is still the responsibility of the NHS following discharge from a hospital ward – for example, a 'step-down' service or rehabilitation of some kind – then the NHS should keep this under regular review.
  - If the services you're receiving are NHS continuing healthcare (NHS CHC), see Factsheet 20w *NHS continuing healthcare and NHS-funded nursing care in Wales* for specific information on monitoring and reviewing these packages.

The above points are covered in further detail in subsequent sections of this factsheet and/or in other Age Cymru titles – where applicable, reference is made to the relevant factsheets in the text.

Note: You should never be formally discharged from hospital until your condition is stable and you can be safely moved. Until then a consultant is usually responsible for your care (if you are in a community hospital, this doctor could be a GP). If you felt that you were in a situation where a hospital discharge process was being unduly rushed, you could consider using the NHS complaints procedure – see section 16 below.

3.2 Discharge planning to begin at the point of admission

The NHS Wales guidance *Delivering optimal outcomes and experience for people in hospital* stresses that "discharge planning must begin at the point of admission".

Within **24 hours** of a decision to admit someone to hospital, the outcomes of conversations and decisions on the following should be documented in the patient's notes:

- A detailed **'what matters to me'** conversation (to include the four main questions outlined in section 2.3 above) "needs to be undertaken with the patient and their family and/or carers".
- "All patients should have an estimated date of discharge…that has been discussed and agreed with the patient and their family and carers".
- "All patients should be allocated to a D2RA pathway" (also see section 3.4 below).
- "A plan should be in place to prevent deconditioning and prioritise availability of take-home medicines at discharge"[4] (also see section 3.5 below in regard to 'deconditioning').

[4] Ibid

3.3 Hospital discharge flowchart

Note: The information in this section is a summary based around hospital discharge practices, built up over a long period (and covering the general ethos contained in a range of guidance documents and material published over time). Section 3.4 below which covers *Discharge to Recover then Assess (D2RA)* – a recent process introduced by the Welsh Government – expresses the same sort of options in terms of 'low level', 'short term', or 'long term' needs and post-discharge services to support these, although it is presented in a slightly different way, using 'pathways'.

Patient admitted

- Agree and start treatment.
- Provide information and discuss discharge process.
- Share estimated date of discharge.
- Start discharge planning and identify what assessments are needed.
- Identify short and/or long-term needs (see section 9 below)
- Discuss care and support options.

Carer/family

Staff should:

- Keep them informed of issues that affect them.
- Assess carer's ability to provide support.
- Assess carer's own support needs.

Patient almost ready for discharge – care needs assessment to take place

Care needs assessment shows need for **short term, time-limited, support**.	Care needs assessment shows patient likely to need **long term care**.	Care needs assessment indicates relatively **low level need** (below eligible threshold for social services assistance).
Possible services (may be NHS *and/or* social services provision. Services may be delivered in your own home, or may be another setting): ● **Reablement** ● **Intermediate care** ● **'Step-down' services** ● **Rehabilitation services** ● **Temporary care home stay** **Note:** When these services end, you may be assessed as needing long-term care after all, or that you now have low level needs – *see the columns to the right*.	Possible services: ● **Home with support via social services**, for example ➢ Personal care; *and/or* ➢ provision of aids, adaptations *and/or* assistive technology. ● **Care home accommodation via social services** ➢ Residential; *or* ➢ nursing home. ● **NHS CHC** ➢ nursing home; *or* ➢ possibly in your own home. ● **NHS palliative care**	No formal care package will be put in place, but staff should discuss the following with you, where appropriate: ● GP and other community NHS services (though the latter might often form part of a higher level care package); ● home from hospital support and possible help with domestic tasks (may be delivered by a charity, such as your local Age Cymru); ● provision of general information on local services and ways to maintain independence.

Note: Some of the various services or options listed above will be covered in more detail later on in this factsheet, or via some of our other factsheets and guides – see the list of suggestions in section 1 above, or access all our guides and factsheets on our website at:

www.agecymru.org.uk/information-resources

3.4 Discharge to Recover then Assess (D2RA) pathways

The most up to date D2RA pathways have been incorporated into the *Delivering optimal outcomes and experience for people in hospital* guidance. A full copy can be accessed within that guidance (we have also reproduced much of information below).

Note: D2RA is intended to **assist health and social care professionals – particularly "those who deliver and support inpatient care" – to deliver "timely continuity of care and to improve patient flow to discharge"**.

Pathway 0 – No additional support required for discharge

- Patient "fully independent – no further support required".
- "Multidisciplinary Team assessment within hospital 'front door' units to avoid full admission".
- "Patient returns to usual place of residence" (their own home, or care home if this is where they reside).
- Restart previous care services with no changes (for example, pre-existing homecare/community care services the person has already been receiving).

Pathway 1 – Supported home first

- "Patient returns to usual place of residency [but] with short term support".
- Provision of preventative services ("delivered in collaboration with third and voluntary sector organisations". For example, help with meals or shopping.

- New homecare/community care services package to be put in place, or change pre-existing care services (i.e. an increase in services to reflect changed needs.
- “Short term reablement to maximise independence”.
- Therapy, nursing services, or provision of equipment.

Pathway 2 – Short term supported facility

- Transfer to a “non-acute bed [for] rehab/reablement and assessment until able to return safely home”.
- “Unsafe to be at home overnight” and/or “between care calls”.
- Patient “currently needing some care…support [and/or] intervention 24/7”.
- Care and support needs include “specialist rehab” (for example, to aid recovery from a stroke).

Pathway 3 – Complex support

- Patient will be “transferred to a new long term bed” or ‘assessment bed’.
- In some cases, people will be able to return to their usual residence, but with complex support put in place to meet their needs.
- For other people on this pathway, there will be “significant change requiring [a] new placement”; “longer term placement” and/or new services to support “life changing healthcare needs”.
- This pathway may well be appropriate for “complex end of life or mental health needs”.

Note: Pathways 1, 2 & 3

Patients on D2RA Pathways 1 to 3 should be “tracked and followed up to assess for long term needs at the end of the period of recovery. When this is in a community setting, as a social care provision, the responsibility for tracking/follow up rests with social services. When in an NHS facility as an NHS provision, the role remains with the NHS in liaison with social services as appropriate”[5].

[5] Hospital discharge guidance, Welsh Government (December 2023).

3.5 The importance of preventing deconditioning

The *Delivering optimal outcomes and experience for people in hospital* guidance focusses on preventing deconditioning as an important aim in current hospital discharging polices. It states that:

"There is growing recognition that lack of physical activity during hospital stays can have significant negative consequences for patients, especially in older people. Patients lose physical and cognitive abilities within hours if actions aren't taken to prevent deconditioning".

"Deconditioning causes harm to patients and can prolong their hospital stay and prevent them getting back to their home and family. It also can have long term consequences [and, as such it's] the professional responsibility of all staff to implement steps to prevent deconditioning from the moment a patient arrives at a hospital".

Prevention of deconditioning should be an ongoing focus for staff and include regularly assessing issues such as:

- **Functional ability** – has there been a decline in the patient's mobility?
- **Cognitive ability** – "has there been a decline in the person's orientation to time and place"?
- **Continence** – has this started to be an issue, or if the patient already had continence needs, have these started to increase?

Appropriate professionals and other relevant staff should ensure they take action to minimise identified deconditioning risks. As an example, this could include embedding actions into someone's care plan to:

- "maximise mobility and encourage self-care, including eating away from [the] bedside and toileting independently";
- "explain and communicate the specific dangers and risks to the person" (for example, the potential impact on a desire to return to their own home);
- "provide active rehabilitation" activities and services; *and/or*
- provision of information and advice to patients and/or their carers and family on what they can do to avoid deconditioning during their hospital stay.

4 Planned hospital admissions – questions to ask

Discussions with your GP may lead to an outpatient consultant appointment to explore or confirm your diagnosis and discuss treatment options. You may find it helpful to ask for further details on some or all of the following:

- Do I need further tests? If so, what are they for? Where and when can I have them? How long before I get the results and how will I get them?
- What treatment would they recommend and why?
- What are the benefits, side effects, risks and success rates of each treatment they are proposing? How frequently is the treatment required?
- What improvements can I expect in my condition or day-to-day life with each treatment option? When might I start to notice improvements and can I expect a full recovery?
- What would be the consequences of doing nothing or waiting a while?
- Will tests or treatment require me to be an inpatient or day patient?
- If I'm an inpatient, what is the likely length of my stay?
- Is there anything I can do to support my recovery before my treatment, while in hospital and once home?
- How long before I know if the treatment has worked or is working? When will I be able to start going about life as usual? Will I need help at home? If so, what type of help and for how long?
- Is there written information about my health condition, treatment or national or local support groups? Are any websites recommended?
- You should tell staff about your home environment at the moment and any help you have already been receiving from social services. The more they know, the easier it is to ensure you have the right support on leaving hospital and any potential problems that could influence the type of support you need on discharge can be identified in advance.

5 Emergency / unplanned admissions

When care is needed urgently, arrival at a hospital urgent care or emergency department should result in an appropriate assessment of your condition, together with initial treatment. Depending on your needs, one of the following will then occur:

- You may be discharged with or without the need for a follow up appointment (also see the flowchart in section 3.3 above).
- If the issue is more serious, it may nevertheless be possible for you to return home, provided suitable health and social care support can be arranged **promptly**. Many ambulance services and hospital emergency departments have 24-hour access to multi-disciplinary teams of health and social care staff who can try and arrange such care and thus prevent unnecessary hospital admission (also see the flowchart in section 3.3 above).
- It may be decided that you need to stay in hospital for further observation and/or treatment on a medical or surgical ward.

'Goal 5' of the Welsh Government's 'Six Goals for Urgent and Emergency Care'

NHS Wales advises the following in relation to people admitted as an emergency to a hospital. The patient should:

- be reviewed by "an appropriate consultant as soon as possible after admission. This should be no later than 14 hours from the time they were admitted"[6];
- "patients aged 65 and over must have a clinical frailty score (CFS) on arrival into urgent care and those that are frail must have rapid access to comprehensive geriatric assessment (CGA) and rehabilitation"[7].
- "be fully involved in and informed of plans for their treatment, recovery and discharge from hospital" (this will include, on a daily basis, answers to the four *'what matters to me'* questions discussed in section 2.3 above);

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[6] 'Goal 5: Optimal hospital care and discharge practice from the point of admission', NHS Wales website: www.nhs.wales/sa/six-goals-for-urgent-emergency-care/goal-5 (last accessed 15 December 2023).

[7] 'Delivering optimal outcomes and experience for people in hospital', NHS Wales.

- "have a structured patient handover during transitions of care, with a focus throughout on return to home as soon as they are clinically fit to leave";
- "have a patient care plan that includes active intervention to avoid deconditioning, maximise recovery and support independence throughout their hospital stay"[8];
- "have access to rehabilitation regardless of condition and ward to which they are admitted" (this should be "available immediately upon admission, or as soon as the person is medically able to participate to accelerate recovery and reductions in side effects").

6 Hospital admissions and welfare benefits

State Pension

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

Attendance Allowance / Disability Living Allowance / Personal Independence Payment

If you receive Attendance Allowance (AA), Disability Living Allowance (DLA) or Personal Independence Payment (PIP), notify the *Department for Work and Pensions (DWP)* when you go into and come home from hospital – see section 17 below for contact details. Payment is suspended once you have been in hospital more than 28 days, including the day of admission.

Pension Credit

If you receive Pension Credit (PC) Guarantee Credit, losing the above disability benefits can affect the amount of PC you receive. Payment of suspended benefits should resume when you are discharged, unless you start receiving local authority financial support towards permanent care in a care home.

[8] 'Goal 5: Optimal hospital care and discharge practice from the point of admission', NHS Wales website: www.nhs.wales/sa/six-goals-for-urgent-emergency-care/goal-5 (last accessed 15 December 2023).

Carer's Allowance

If you receive Carers Allowance (CA) and go into hospital, it stops after 12 weeks. Tell the DWP when you go in and when you come home from hospital. If someone receives CA for looking after you and you go into hospital, their CA stops when your AA, DLA or PIP is suspended.

Note: You can also contact Age Cymru Advice if you have queries about benefits while in hospital – see section 17 below for contact details.

7 Preparing for discharge

7.1 Your care needs assessment

Note: When people are in hospital, but may need services upon being discharged, NHS and local authority social services staff should work in partnership to carry out an assessment of the person's needs and – as previously mentioned above – there should be a named lead '**Care Coordinator'** and **'Trusted Assessor'** (see section 7.2 below for further information). The level of detail in the assessment and/or the range of health, social care or other professionals involved will be influenced by the complexity and/or severity of someone's needs.

The expectation of joined up working by health and social services in this area is confirmed in various guidance, including that to accompany the *Social Services and Well-being (Wales) Act 2014*:

"Local Authorities should work with their partner local health boards and NHS trusts to agree arrangements across the local health board footprint area for delegating practitioners to undertake assessments for care and support" and local authorities and health services "should ensure they have integrated assessment, care and support planning and review arrangements, which support the wider agenda [of the] integration of social care and health care provision"[9].

[9] Social Services and Well-being (Wales) Act 2014: Part 3 Code of Practice (assessing the needs of individuals), Welsh Government

Broadly speaking, an assessment means collecting and recording information to help understand more about your needs and circumstances and how they might affect your daily living and quality of life. This could include your personal care needs; health needs including emotional / psychological needs; or whether you require nursing care or help from other health professionals. It can also identify whether providing aids or adaptations will make life easier and safer.

Depending on the complexity of your needs, the assessment may involve one or more of the following professionals:

- NHS staff in the hospital – e.g. consultants, junior doctors and nurses;
- Other NHS staff – e.g. GP, community nursing teams;
- mental health teams;
- sensory needs teams;
- local authority social services departments;
- occupational therapist (OT);
- physiotherapists;
- speech therapist;
- pharmacists;
- staff from local authority or voluntary sector housing schemes;
- care home staff;
- independent domiciliary care provider staff;
- charity/voluntary agency staff providing services such as ‘home from hospital’, ‘help at home’ or ‘Good Neighbour Schemes’.

See Age Cymru’s Factsheet 41w *Social care assessments for older people with care needs in Wales* for further information on care needs assessments.

7.2 The roles of the Care Coordinator and Trusted Assessor

The Care Coordinator

The Care Coordinator plays an important role of ensuring continuity and consistency in the assessment and care planning process. They will be expected to ensure “all practicalities are addressed”. This could include “availability of existing care provider[s], transport arrangements, medication [and other] discharge communication[s] etc”[10].

The role can be undertaken by the health or social care professional with the largest contribution to the discharge process or, alternatively, in some cases a community-based Care Coordinator already allocated to the patient may be able to continue in this role during a short or planned hospital stay.

The following are examples of who might be the Care Coordinator (depending on individual circumstances):

- the lead nurse;
- discharge liaison nurse;
- chronic condition nurse;
- a social worker;
- physiotherapist;
- occupational therapist.

The person acting as Care Coordinator may sometimes change as the patient progresses through their care and treatment.

Trusted Assessor

According to the general Welsh Government hospital discharge guidance, the Trusted Assessor role involves “someone acting on behalf of and with the permission of multiple organisations – carrying out an assessment of health and/or social care needs in a variety of health or social care settings”.

[10] Hospital discharge guidance, Welsh Government (December 2023).

"The aim is to avoid unnecessary duplication and delays to discharge"[11]. There appears to be some overlap with the Care Coordinator responsibilities.

More specific guidance clarifies that the Trusted Assessor role requires "skills and competence, to undertake a **proportionate assessment** on behalf of another organisation to support a discharge from hospital to the persons next stage in their care journey" (emphasis added).

"The proportionate assessment undertaken in a hospital [or] inpatient location should focus on all the needs to enable the person to return home or [enter the] next stage of care", with "more comprehensive, or specialist assessments [potentially then being] undertaken in the person's own environment".

Therefore, the Trusted Assessor, though being a "hospital-based health or care professional" may act "on behalf of the local authority [and, if so] the assessment will be undertaken as part of the Social Services and Well-being (Wales) Act 2014 requirement to assess a person's need for care and/or support"[12]. The Trusted Assessor functions align with the Discharge to Recover then Assess (D2RA) Pathways.

7.3 Independence Checklists

The Welsh Government's December 2023 hospital discharging guidance advises that "an important factor in determining the right level of support a person may need will be their level of independence". Therefore, this should be a key factor in the person's discharge planning and care needs assessment. The guidance makes reference to the **British Red Cross Five Part Independence Checklist**. This lists a number of areas, as set out below, that can impact on someone's level of independence and is useful "guidance for staff and multi-disciplinary teams working with the patient to consider":

[11] Ibid

[12] Guidance Module 2: Trusted Assessor for Hospital Discharge For Adults, NHS Wales.

- **Practical independence** – “for example, suitable home environment and adaptations”.
- **Social independence** – “for example, risk of loneliness and social isolation [and whether someone has] meaningful connections and support networks”.
- **Psychological independence** – for example, how the person is “feeling about going home [and] dealing with stress associated with injury”.
- **Physical independence** – for example, “washing, getting dressed, making tea” and/or “mobility…for example, need for a short-term wheelchair loan”.
- **Financial independence** – “for example, ability to cope with financial burdens”[13].

7.4 Your carer’s role in the needs assessment process

On admission, most hospitals ask you who you would like them to contact in an emergency. If you want your family or carer to be informed or involved in discussions about your treatment or discharge arrangements, tell hospital staff and ask them to record this in your notes.

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

Your carer’s own needs and opinions should **also** be considered and taken into account as part of your assessment.

Staff should give your carer information that enables them to safely carry out tasks they agree to undertake on your behalf.

Carer’s assessments

Your carer can **also** ask for a separate carer’s assessment to identify any services they need to support them in their caring role.

Carers can request an assessment, even if the person cared for does not want one for their needs.

[13] Hospital discharge guidance, Welsh Government (December 2023).

Where a carer may be taking on a caring role for the first time

NHS and social services staff should be mindful of situations where someone is going to be caring for a relative or friend for the first time, upon the patient's discharge from hospital (for example, because the person didn't have particularly high needs before, but these have now increased). They should ensure the "referral of newly identified unpaid carers…for a Carers Needs Assessment, where appropriate"[14].

Identifying carers

Local Health Boards and local authorities should "work closely to identify any new and existing unpaid carers that may be involved with the patient at the earliest opportunity. Early identification of unpaid carers should mean that any support available can be provided in a timely manner and to maximise its impact"[15].

7.5 Making decisions and giving your consent

Staff must seek your permission to carry out tests, treatment or an assessment of your care needs and to share this information with relevant professionals. If someone seems unable to make these decisions, staff should ask family members if the person:

- usually needs help to make decisions;
- has made a health and care decisions Lasting Power of Attorney (LPA) (see Age UK's Factsheet 22 *Arranging for someone to make decisions on your behalf* for more information on LPAs);

or

- whether a deputy has been appointed by the Court of Protection (CoP) to act on the person's behalf (also see Factsheet 22 for further information on CoP appointed deputies).
- They should also ask if the person may have made an advance decision to refuse treatment (for further information, see Age UK's Factsheet 72 *Advance decisions, advance statements and living wills*).

[14] Ibid
[15] Ibid

If you have not appointed anyone to act on your behalf and staff confirm you lack capacity to give consent or make a decision when it needs to be made, **an appropriate member of staff must make a decision in your 'best interests'** under the *Mental Capacity Act 2005*.

To inform their decision, staff should consult people who appear to have a genuine interest in your welfare. This usually includes family and friends as they can provide valuable information about you and your circumstances.

Independent Mental Capacity Advocates (IMCAs)

If someone does not have any suitable family or friends to consult, NHS or local authority staff should appoint an Independent Mental Capacity Advocate (IMCA) if they need to make a 'best interests' decision on the person's behalf involving:

- serious medical treatment;
- a permanent change of residence; *or*
- a temporary change of residence, lasting more than eight weeks.

The IMCA's role is to work with the person and support them to make sure that their wishes and feelings can be communicated to those professionals making best interests decisions.

As touched upon above, the *Mental Capacity Act 2005* is the legislation which governs the rules to be followed where someone lacks capacity to make their own decisions and applies to anyone seeking to act in that person's 'best interests'.

Doctors, nurses, social workers, other health professionals and support staff have a duty to ensure they are trained in its implementation and are expected to understand it as it relates to their own responsibilities.

The Act aims to protect people who cannot make certain decisions for themselves and empower them to make decisions wherever this could be possible (for example, with certain help that could enable them to do so in particular situations, even if not all the time).

Further information on the Mental Capacity Act 2005

Further information can be found on the GOV.UK website at:

www.gov.uk/government/collections/mental-capacity-act-making-decisions

8 Advocacy services – for support during the care needs assessment and care planning processes

8.1 What is advocacy?

Advocacy services support people who have difficulty expressing their views to exercise their rights and explore and make informed choices. “Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy schemes work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and social justice”[16].

8.2 Advocacy from a charitable or voluntary organisation

Some local Age Cymru organisations may be able to provide advocacy services (or know of other local organisations who can). Contact **Age Cymru Advice** who should be able to let you know of any advocacy provision in your area – see section 17 below for contact details.

You could also try searching on the Welsh Government’s Dewis Cymru website at:

www.dewis.wales

8.3 Advocacy from Llais (a statutory and independent voice)

Llais are a statutory and independent voice whose role is to represent the interests of the public in the health and social care services in their area. They may be able to provide advocacy during:

- a hospital stay; *and/or*
- during the discharge process; *and/or*

[16] Social Services and Well-being (Wales) Act 2014: Part 10 Code of Practice (Advocacy), Welsh Government

- in relation to subsequent health or social care services.

You can contact Llais in your area via the following link (or you can use one of the other ways of contacting them in section 17 below):

www.llaiswales.org/in-your-area

Llais have dedicated complaints advocacy staff who you could contact when making a complaint about the NHS (or social services). Their service will be free, independent, and confidential. They can "provide a step-by-step guide to the [complaints] process", offer some tips and explain your options[17].

The Llais complaints advocacy service may be able to help with some, or all, of the following (depending on individual circumstances):

- help you "think through your concerns…and what you might realistically achieve";
- assist you to work out what you want to say and help with drafting letters; *and/or*
- "support you to prepare for and attend meetings with staff"[18].

Further information can be found on the Llais website at:

www.llaiswales.org/have-your-say/raising-concern-about-health-and-social-care-services/llais-advocacy-guide

[17] 'Raising a concern about health and social care services', Llais website: www.llaiswales.org/have-your-say/raising-concern-about-health-and-social-care-services (last accessed 6 December 2023).

[18] 'Llais Complaints Advocacy Guide', Llais website: www.llaiswales.org/have-your-say/raising-concern-about-health-and-social-care-services/llais-advocacy-guide (last accessed 11 December 2023).

8.4 Rights to advocacy under the Social Services and Well-being (Wales) Act 2014

Advocacy if the local authority social services department is going to be arranging your post-discharge services

In addition to Llais (detailed in section 8.3 above), the *Social Services and Well-being (Wales) Act 2014* provides certain rights to advocacy support in relation to the social care assessment process. In many instances, the requirement on the local authority will be to make people aware of the availability of advocacy support, should they wish to utilise this; in others the authority will have a *specific duty* to "**arrange an independent professional advocate**" for someone[19].

Authorities are advised in Welsh Government guidance that they "**must** arrange for the provision of an independent professional advocate when a person can only overcome the barrier(s) to **participate fully in the assessment, care and support planning, review and safeguarding processes** with assistance from an appropriate individual, ***but there is no appropriate individual available***" (emphasis added)[20].

In other words, this would be where an individual is finding it difficult to express their views in the assessment process, but there are no immediate, or suitable, family or friends to help them, nor is the individual able to independently access, for example, an advocacy service provided by a voluntary organisation.

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[19] Social Services and Well-being (Wales) Act 2014: Part 10 Code of Practice (Advocacy), Welsh Government

[20] Ibid

Note: The Welsh Government have recognised the potential for confusion where people could qualify for different statutory entitlements to advocacy at the same time – for example, as well as being owed a duty under the *Social Services and Well-being (Wales) Act,* an authority "may identify a duty to provide an Independent Mental Capacity Advocate (IMCA) under the Mental Capacity Act 2005" – **section 7.5 above has information on the role of IMCAs**.

In these instances the authority "must meet its duties in relation to working with [the] IMCA...as well as those in relation to an independent professional advocate under the [*Social Services and Well-being (Wales)*] Act". An advocate can potentially act in **both** roles as the duties of each "have been closely aligned so as to facilitate this"[21].

9 Drawing up your care plan following the care needs assessment

As outlined in the flowchart in section 3.3 above, once your assessment is complete – and having considered the options – staff may either conclude that:

- You have low level needs that do not require any formal service provision – though you may still benefit from other assistance, such as from a charitable organisation. See section 10 below.
- You have care needs, but they feel there is a realistic potential for you to improve after a certain recuperation or recovery period. They will therefore discuss and agree with you a **care plan to meet short term goals** – see section 11 below.
- You are likely to require ongoing services and thus discuss and agree with you a **long term care plan** – see section 12 below.

[21] The aim here is to achieve "continuity in individuals' advocacy needs, minimising duplication including the need for the individual to have to repeat their experiences and desired outcomes to different advocates. Wherever possible, the parties [involved] should...agree a single advocate to support the person" – Social Services and Well-being (Wales) Act 2014: Part 10 Code of Practice (Advocacy).

9.1 Details that the care plan should include

The details of your care plan should be in proportion to your needs and the complexity of the services to be provided. It could include:

- what NHS and social care support you will receive and its purpose;
- who will provide the support, how often and when;
- details of what your carer is willing to do, their needs and how they will be supported in their role;
- any concerns you or your carer may have;
- the results of any risk assessment/s undertaken in relation to the services to be provided;
- who is co-ordinating your care plan and who to contact in an emergency or if the services are not meeting your needs;
- if the services attract a charge – generally because they are social care, rather than NHS services – how much you have been assessed as needing to pay towards this (also see sections 11 and 12 below);
- monitoring arrangements and when your care package will be reviewed.

10 Post-discharge services that can be arranged as part of your care plan – options if you have low level needs

You may need help with domestic tasks that fall below the eligibility threshold for local authority social services assistance (and thus you may not qualify for a formal care package). For example, you might need help for a week or two with shopping, cleaning or general housework.

Note: In some cases low level services might be provided *alongside* social services provision – such as personal care – or NHS provision. If so, then you may have been assessed as having higher level or longer term needs – therefore, also see sections 11 and 12 below.

10.1 ‘Home from hospital’ or ‘hospital discharge’ services from charitable / voluntary sector organisations

The local charitable and voluntary sector, such as local Age Cymru organisations, Age Connects, the British Red Cross or Care & Repair Cymru may offer **‘home from hospital’** or **‘hospital discharge’** services during your first few weeks back home.

If voluntary organisations are to provide support on discharge, best practice will be for them to be involved in the assessment and care planning process, so the services can be in place straight away through liaison between staff at the hospital and/or social services and the voluntary organisation concerned. However, if for any reason this doesn’t seem to be happening, you can contact the organisations yourself to request their assistance. **Age Cymru Advice** can provide you with the details – see section 17 below.

Home from hospital and hospital discharge services may be able to assist in the following ways:

- provide or arrange transport home from hospital;
- arrange equipment such as key safes;
- carry out domestic tasks (including potentially helping you to sort out paperwork that accumulated while you were in hospital);
- keep in touch and arrange regular chats or friendship calls;
- safety checks to ensure you are managing on your own;
- carry out essential food shopping;
- coordinate support between other charitable/voluntary organisations that may also be providing services.

10.2 Other services from charitable / voluntary sector organisations, or a private agency

The following services may also be available which could help you to adjust to living back home following a hospital stay:

- befriending;
- advocacy;

- the loan of equipment such as wheelchairs and commodes;
- handyperson schemes.

Contact Age Cymru Advice for further information – see section 17 below for contact details.

Note: You could also choose to use a **private agency** to meet lower level needs (section 12.8 below has some further information on private care agencies).

Age Cymru's Factsheet 6w *Finding help at home in Wales* may also be useful.

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11 Post-discharge services that can be arranged as part of your care plan – options if you have potential to improve in the short term

If you need support to re-build your confidence and maximise your ability to live independently then your assessment prior to discharge should identify a period of intermediate care, reablement or rehabilitation services as an option. These services might enable someone to recover sufficiently to stay living in their own home and so should be considered seriously as an option by staff, before a decision is reached that someone needs to move into a care home on a permanent basis, for example.

Note: Broadly speaking, intermediate care services, reablement or rehabilitation services must have the aim, through therapy or treatment, to support someone to recover or maintain their ability to live independently at home. Services without these characteristics would be unlikely to meet this classification. For example, in the case of personal care services provided in someone's own home by social services, there may well be no expectation that the person will realistically reach a point when support is no longer needed and thus the support will be provided *indefinitely*; whereas, intermediate care, reablement or rehabilitation services are provided on a **short term basis** because the person has been assessed as having the capability to regain some or all of their ability to carry out daily living tasks.

The sub sections below contain brief introductory information on these topic areas. You may also wish to have a look at Age Cymru's Factsheet 76w *Reablement, intermediate care and preventative services in Wales*.

11.1 Intermediate care

Intermediate care describes a range of services providing time limited support – **up to 6 weeks** – for NHS patients, with the aim of promoting independence by:

- facilitating a timely discharge from hospital;
- avoiding unnecessary hospital admission;
- avoiding hospital **re-admission** for those who have already had a hospital stay; *or*
- avoiding admission to a long term care home placement.

Intermediate care services should maximise people's rehabilitation and recovery after illness and typically enable them to resume living at home.

Note: Intermediate care services are provided **free** of charge.

11.2 Reablement services

Reablement services aim to encourage and support people to learn or re-learn skills necessary for daily living, following a period of illness or after a stay in hospital. Reablement support is about helping you to discover what you are capable of doing for yourself, and to give you confidence when moving around your home and with tasks such as washing, dressing and preparing meals.

Reablement services are most frequently delivered in your own home, **though there is some overlap with recent NHS Wales guidance on 'Step-down' services** (also see the following section, 11.3).

Staff will discuss and assess your needs to find out what you can do and what is causing difficulty. You will then agree a plan describing the support you will need to help you improve.

The emphasis is on staff supporting you to attempt and complete tasks described above rather than undertaking tasks on your behalf – helping you discover what you can do for yourself and giving you the confidence to try.

As with intermediate care, most reablement services are provided for up to six weeks, although it can sometimes be extended if required.

Note: Reablement services are provided **free** of charge.

11.3 NHS rehabilitation services (including 'Step Down to Recover' bedded facilities)

Rehabilitation services aim to promote your recovery and maximise your independence if, for example, you have had a heart attack or stroke, or an acute attack of a chronic illness such as Parkinson's or multiple sclerosis. **Services often begin while you are in hospital and continue for weeks or months once you leave**.

You may receive support from a range of health professionals on an individual basis or in a group setting. Staff involved include physiotherapists, occupational therapists or speech therapists who can help with both speech and swallowing difficulties.

'Step Down to Recover' bedded facilities

NHS Wales guidance advises that Step Down to Recover services will be aimed primarily at people aged 60+ and may be applicable in the following circumstances (this is not an exhaustive list, however):

- Where people are ready to be discharged from hospital – and "no longer meet the criteria for an acute hospital bed" – "but are unable to return to their former home [and] require further rehab or reablement in a place other than their usual residence" to reach the best level of independence possible.
- Where "care and support required at home is not currently available" and it would be unsafe for the person to return to their own home "pending a start date for community packages of care" (i.e. where there'd be a gap in-between where there would be a danger that no help would be provided).

- Potentially where individuals have a cognitive impairment or dementia (consideration will need to be based on individual needs and circumstances, where more specialist intervention “such as Dementia/Memory Rehab” may also need to be put in place).
- Where someone is “awaiting assistive equipment and minor adaptations to their home and will benefit from a discharge to recover community bedded facility” in the meantime.
- Where individuals “are homeless”; “have no right of recourse to public funds” and/or “no place to safely discharge to” (though this “should not hinder the process to resolve their ongoing housing needs”).

Note: As with the other services discussed in this section, step down to recover assistance should “be time limited, with the expectation to…move people to the desired pathway home as soon as possible”. Services “can be extended subject to continued review and a defined end date for people to return to their own home”[22]. NHS rehabilitation services and ‘Step Down to Recover’ services should be provided **free** of charge.

11.4 Support from community-based NHS staff and provision of medical equipment

If appropriate to your care needs you should be provided with the following free of charge:

- Support from your GP.
- Support from other community-based NHS staff, such as:
  - district nurses;
  - continence nurses;
  - dieticians; *or*
  - community mental health nurses.
- Continence pads and related products identified as necessary during your care needs assessment.

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[22] ‘Step-down to Recover (SD2R): National Minimum Service Guidance’, NHS Wales.

Note: Some of the above services may also be equally relevant for people with long term care needs – see section 12 below.

11.5 Temporary stay in a care home

Where someone still wishes to return to live in their own home – so don't wish to take the step straight away of living permanently in a care home – the local authority social services department may be willing to agree a temporary care home stay.

Age Cymru's Factsheet 58w *Paying for temporary care in a care home in Wales* has further information on this topic, including how this type of care is means tested.

12 Post-discharge services that can be arranged as part of your care plan – options for long term care needs

12.1 NHS continuing healthcare

The NHS is responsible for meeting the full cost of care (most often in a care home, but sometimes in your own home) for those whose **'primary need'** for care is health-based. In other words, your needs are beyond those that the local authority has a duty to meet, due to the level of the health-related element. This is called **NHS continuing healthcare** (NHS CHC) and is often described as 'fully funded care'.

Where it is judged that the primary reason for someone needing care is *health-based* (rather than *social care needs based*), someone is entitled to:

- healthcare, which is **free**; rather than
- social care, which is often ***means tested***.

If you receive this type of care, part of the overall package may include care and support more usually provided by local authorities – *however*, if it is provided by the NHS as part of continuing healthcare, it will be free.

Note: An issue which can often cause debate is the difference between what constitutes a healthcare need and what constitutes a social care need. The Welsh Government previously published 'Practice Guidance' which defined the difference between a healthcare and a social care need as follows:

"Whilst there is not a legal definition of a healthcare need (in the context of continuing NHS healthcare), in general terms it can be said that such a need is one related to the treatment, control or prevention of a disease, illness, injury or disability, and the care or aftercare of a person with these needs (whether or not the tasks involved have to be carried out by a health professional)".

In contrast, "in general terms (not a legal definition) it can be said that a social care need is one that is focused on providing assistance with activities of daily living, maintaining independence, social interaction...and (in some circumstances) accessing a care home or other supported accommodation. Social care needs are directly related to the type of welfare services that [local authorities] have a duty or power to provide. These include...practical assistance in the home; assistance with equipment and…adaptations; visiting and sitting services; provision of meals; facilities for…social, cultural and recreational activities outside the home...and assistance in finding accommodation (e.g. a care home)"[23].

Guidance for determining NHS CHC eligibility

The assessment procedure for NHS CHC is contained in the following Welsh Government guidance document:

NHS Continuing Healthcare: The National Framework for Implementation in Wales *(Published: July 2021; Implemented 1 April 2022)*.

A copy can be accessed at:

www.gov.wales/national-framework-nhs-continuing-healthcare

[23] 'Continuing NHS Healthcare for Adults: Practice Guidance to support the National Framework for Implementation in Wales – Frequently Asked Questions, Welsh Government, November 2010'. This particular guidance is no longer in use – however, the general principles regarding differences in social care needs and healthcare needs are still helpful as background information.

This guidance should be used by all professionals – medical staff, social workers etc – involved in making eligibility decisions for CHC.

If the nature of your needs indicate that you might be eligible for NHS CHC, those involved in your care must actively consider this possibility, inform you or your representatives of your rights, and initiate the relevant CHC assessment procedures.

To move to the social care means test without addressing the potential right to free NHS service provision may constitute poor professional practice and could be challenged.

More information on NHS CHC can be found in Age Cymru's Factsheet 20w *NHS continuing healthcare and NHS-funded nursing care in Wales*.

If after looking at the above factsheet and/or the Welsh Government's 'National Framework', you feel that your need for NHS CHC has not been addressed at all – or adequately – you can bring the issue up with health or social care staff working with you and ask for an assessment to be carried out (or ask for an initial decision to be reviewed).

12.2 Local authority social services assistance in your own home and/or in other community settings

If a local authority establishes via the care needs assessment that your needs fall within the national eligibility criteria (that you have 'eligible needs'), the authority then has a **legal duty** to arrange or provide services for you to meet those needs.

Depending on individual needs, a wide range of services may potentially be available; for example:

- **Personal care** (help with tasks such as getting up; dressing; using the toilet; washing and bathing or eating and drinking);
- **home help / domestic assistance**[24];

[24] In many areas local authorities have reduced or discontinued domestic help in order to direct resources towards personal care. However, they still have a legal duty to meet assessed eligible needs, which may include elements of these services as part of an overall care package, where you have *other* eligible needs. Alternatively, as touched upon in sections above, if you only need help with domestic tasks (but do not qualify for local authority assistance), some local Age Cymru organisations – or other voluntary agencies – may provide help with various household tasks. You may also be able to purchase help at home from a private agency or employ someone directly yourself – see section 12.8 below.

- **pre-prepared meals delivered to someone at home** ('meals on wheels');
- **day care** (i.e. away from the home in, for example, local authority run day centres for older people);
- **community transport**;
- **provision of aids, equipment *and/or* housing adaptations to help with daily living tasks and for home safety**;
- **provision of telecare, including personal alarms, or other assistive technology**;
- **preventative and rehabilitation services** (including reablement, as covered in section 11 above);
- **respite care in various forms**.

Note: Age Cymru's Factsheet 6w *Finding help at home in Wales* has further information on each of the listed services above, whilst some of Age Cymru's other social care titles will contain more detailed information on specific services (for example, Factsheet 42w *Obtaining disability equipment and home adaptations in Wales* deals with the provision of equipment and adaptations).

Means testing and paying for services in your own home from social services

You will generally be **means tested** by the local authority if it is intending to provide you with a social care service.

In most cases you will have to pay at least something towards the cost of your care. However, for people receiving services upon being discharged from hospital, there may be an **initial element of free care** – see section 11 above).

The means test will include looking into:

- your capital (savings); *and*
- income.

Welsh Government guidance specifies that people must be left with a minimum income after paying for their services.

There is also a maximum weekly charge for homecare and other non-residential social care services.

If you are a homeowner, the value of your main or only home must be disregarded in the means test.

Age Cymru's Factsheet 46w *Paying for care and support at home in Wales* has in-depth information on local authority charging procedures, including:

- **types of income and capital that are taken into account in the means test** (and those that can be disregarded);
- **the current maximum weekly charge**;
- **your minimum income after paying your charge** (and how the local authority should calculate this).

Direct payments for meeting your eligible social care needs

The standard procedure for non-residential social care is for the local authority to provide the services it has assessed you as needing directly – be this via their own staff employed by the authority, or by contracting a private care agency to operate the service/s on their behalf. Either way, the services are provided for you and you don't have to organise anything yourself.

However, some people prefer to have more choice and control over the services they receive in order to meet their eligible care needs. Direct payments offer this facility – they are cash payments that local authorities can make to individuals so that they can organise their own social care services (either by employing a carer worker themselves, or by using a local home care agency).

Age Cymru's Factsheet 24w *Direct payments for social care services in Wales* has further information on this topic.

12.3 Sheltered housing

Sometimes a social care assessment will identify sheltered housing as a potential way to help people meet their needs.

This could include 'extra care' sheltered housing. This is a type of 'housing-with-care' – housing in which personal care services, such as help with bathing and dressing, are provided.

The local authority social services department would need to liaise with their counterparts in the housing department in regard to the possible allocation of sheltered housing.

Age UK's Factsheet 64 *Specialist housing for older people* contains further information. Age Cymru's Factsheet 8w *Community landlord housing in Wales – local authority or housing association homes* may also be helpful.

12.4 A permanent place in either a residential or nursing home

You may need, or wish, to move to live in a care home. These divide into broadly two types – residential and nursing – which provide accommodation with either:

- just personal care; *or*
- personal care together with nursing care.

Your social worker will help you identify which sort is appropriate for your needs.

- Residential care homes provide only social care staff; they do not provide any nursing staff and so medical care should be provided by NHS staff coming to the home when necessary.
- Nursing homes are for people who have specific nursing needs and they employ a mixture of social care and nursing staff.

Further information on care homes can be found in Age Cymru's Factsheet 29w *Finding care home accommodation in Wales*.

Means testing and paying for care in a care home

Most people living in care homes pay something towards the cost of their care. This is either:

- in full, from income and/or capital – i.e. they will be a self funder; *or*
- they will make a contribution towards the overall costs, with the local authority meeting the rest of the fees (in these circumstances, the authority will be responsible for paying the whole fee to the care home and the resident will then pay to them their 'assessed contribution'. The assessed contribution is determined according to nationally set means test rules.

Income and capital will be taken into account in the means test, though certain types may be disregarded (ignored), either in all cases, or when certain circumstances apply (for example, if you are a homeowner, the value of the property will generally be taken into account if you live alone and go into a care home; whereas, if your partner will remain there, it will be disregarded).

There is a nationally set 'capital limit' which determines whether someone will be expected to self fund (capital over the limit), or make a contribution towards the overall fees alongside local authority financial assistance (capital below the limit).

If you move into a nursing home, the NHS is responsible for meeting the cost of care provided by a registered nurse on site. This is made via a *weekly* NHS funded nursing contribution towards the overall fee.

For more detailed information on the means test rules you can view our factsheets listed below. They cover issues including:

- **the current capital limit**;
- **how different types of income and capital are treated**;
- **how your property will be treated and when it may qualify to be disregarded**;
- **considerations when choosing a care home**; *and*
- **the NHS funded nursing contribution**.

Factsheets with in-depth information on care homes:

- 10w *Paying for a permanent care home placement in Wales*;
- 38w *Treatment of property in the means test for permanent care home provision in Wales;*
- 39w *Paying for care in a care home in Wales if you have a partner*;
- 60w *Care homes in Wales: choice of accommodation when the local authority is assisting with funding*.

12.5 Options where a large amount of care is needed, but someone doesn't want to be discharged to a care home

If a large amount of care is required to enable someone to remain living in their own home or in sheltered housing, it might be cheaper and/or be a more practical way to adequately meets someone's care needs for them to move into a care home.

This can lead to difficult situations – for example, where someone feels very strongly that they do not want to live in a care home environment and wish to return to live in their own home, following a hospital stay.

People cannot be made to move into a care home against their will, provided they are still mentally capable of making the decision for themselves (further information on mental capacity can be found in section 7.5 above). Nevertheless, you may be advised – following a care needs assessment – that a care home is the only safe and effective way of meeting your care needs.

If you do not want to move into a care home, you are of course entitled to say so, and can ask your social worker to explore again whether there are some specific services – or combinations of services – that could adequately and safely meet your needs in your own home (to an equivalent level as in a care home). Many local authorities set a limit on how much care they will provide or arrange to support someone in their own home (or in sheltered housing) before suggesting that the person move to a care home. Any such limit must be applied flexibly, however.

Note: It's important to bear in mind that people do **not** have the right to occupy an acute hospital bed indefinitely and will need to move to a more appropriate care location when clinically ready.

Therefore, any disputes about what services are to be provided post-discharge may need to be resolved quickly. As such, you may find an **advocacy service** helpful to achieve this and make sure that your views are fully taken into account – see section 8 above in regard to advocacy.

Apart from any other considerations, a prolonged stay on a busy acute hospital ward may not be in someone's best interests, as it could lead to depression and boredom and/or an increased risk of infection; ultimately reducing someone's ability to maintain mobility and independence.

The recent NHS Wales guidance on *'reluctant discharge'* may also become relevant in these sorts of situations – see section 14 below.

A possible alternative to a care home placement is an arrangement with the local authority, whereby homecare is provided that doesn't fully meet your needs, but you then make separate arrangements to run *alongside* this – Age Cymru's Factsheet 41w *Social care assessments for older people with care needs in Wales* has some further information on this option.

It should be noted that, legally, the local authority is under a duty to meet your eligible needs as identified in the care needs assessment; however, it is able to do so in the most cost-effective way.

Whilst this means the authority cannot choose a care package for you for the *sole* reason that it is cheaper than the alternatives – for example, you shouldn't be asked to move to a care home just because it is cheaper than the home care you would need (or vice versa) – if there were **two** options that would meet your needs equally well, the local authority can legitimately choose the option that is cheapest for it to provide or arrange.

However, having said this, the local authority would have to ensure that the cheaper option met **all** assessed and agreed needs.

As an example, it wouldn't be sufficient if the cheaper provision would meet your personal care needs (say, help with washing and eating), but was going to leave other needs unmet that were identified during the assessment (such as the service user being able to maintain family or other significant personal relationships; or involvement in the community – the care option/s that the local authority chooses must meet these sorts of needs too).

This is confirmed in Welsh Government guidance[25] – namely, that people's needs must be identified during assessment and, although these will differ in each case, they must relate to the wellbeing definitions in the *Social Services and Well-being (Wales) Act*. The wellbeing definitions in the guidance include statements about the maintenance of important relationships, as do the personal outcomes to which eligible care and support needs must relate (i.e. relationships and involvement in the community are mentioned alongside other 'practical' needs such as ability to carry out self-care and/or domestic tasks).

All the wellbeing factors are of equal importance in the guidance.

It is also worth mentioning here, in the context of a local authority choosing care and service options, that this choice must be made in conjunction with the service user. In other words, if you felt that the authority had not adequately involved you in the decision process regarding your care and support, you could ask them to reconsider a decision, or make a complaint, outlining these points to them. See section 16 below for further information on making a complaint. As indicated above, you might find advocacy support helpful if you wish to pursue a complaint with the local authority (see section 8).

There might also be scope for a human rights based approach to negotiating or disputing a local authority position – also see section 16 below for further information.

[25] Social Services and Well-being (Wales) Act 2014: Part 3 Code of Practice (assessing the needs of individuals), Welsh Government

12.6 Self-management support from the NHS

NHS staff should help and encourage people with long-term conditions to be more involved in their care, to feel confident to take decisions about its day-to-day management and recognise changes that need to be reported promptly to their GP. On-going support can be offered as part of hospital follow-up care, or consultations with your GP, practice or specialist nurse.

Self-management courses are arranged in many areas of the country. These are designed to give you the confidence, skills and knowledge you need to manage your condition and provide an opportunity for participants to learn from and support each other.

For example, your consultant, specialist nurse or GP may be able to provide you with information on courses operated by EPP Cymru (Education Programmes for Patients).

Note: The NHS Wales website has further information on EPP Cymru at:

www.phw.nhs.wales/services-and-teams/improvement-cymru/our-work/education-programmes-for-patients

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12.7 NHS palliative care

Palliative care describes the holistic care offered when you have been diagnosed with a progressive illness that cannot be cured. Palliative care services should improve the quality of life of patients through the prevention and/or relief of suffering and pain. A range of services can be available to you at the point of diagnosis and then be on hand as and when you need them. The aim being to keep you comfortable and ensure the best quality of life at all stages of your illness.

Throughout your illness services may be available to you in your own home, in the local hospice or hospital and might include the support of doctors, nurses, hospice staff or ‘hospice at home’ teams, Marie Curie or Macmillan nurses or other professionals – see section 17 below for contact details.

You may wish to discuss how you would like to be cared for as you approach the end of your life with health professionals caring for you, your family or friends. This is known as ‘advance care planning’ and means all those caring for you will be aware of your wishes.

Note: Further information can be found on the NHS Wales website at:

www.executive.nhs.wales/networks/programmes/peolc

12.8 Private care agencies

Private care agencies offer help with a range of personal care tasks, domestic tasks and meal preparation. They must register with – and are inspected by – Care Inspectorate Wales (CIW).

You can read care agency inspection reports on the CIW website or request a copy by phone – see section 17 for contact details.

You may want to buy your services from a private agency if you choose to receive direct payments from social services. Your local authority can provide a list of agencies that provide services locally, or you could use the search facility on the CIW website at:

www.careinspectorate.wales/find-care-service

13 Practical considerations for effective discharge

As well as having an agreed care plan and ensuring services are ready to start on the day you leave hospital, there are practical points that are vital to a safe and smooth discharge:

- Has your carer been given sufficient notice of the date/time of your discharge?
- Do you have suitable clothes to wear on the journey home?
- Is a relative collecting you, or is hospital transport required?
- Do you have house keys and money if travelling home alone?
- Will medication be ready on time? Have changes been made to the medication you were taking on admission and explained to you and, where appropriate, your carer? Are some items to be taken in the short term only?
- Have you and/or your carer received training, so that new aids/equipment can be safely and effectively used? Are aids available to take with you or already in place at home?

- If assessed as requiring them, do you have a supply of continence products and know how to get further supplies?
- Are your GP and other community health staff aware of your discharge date and support you will need from them? Has a discharge summary with details of any medication changes been forwarded to the practice?
- If you are to move into a care home, are they aware of the date and likely time of your arrival, along with your care plan and medication needs?

14 ‘Reluctant discharge’ arrangements

The Welsh Government has sought to address this issue with the release of specific guidance on the topic (also see section 2.5 above).

It advises Local Health Boards that:

“When a person no longer requires care in the hospital setting there are significant risks associated with loss of independence and exposure to risks, such as hospital acquired infections and falls. **The aim must always be to ensure that care to meet assessed needs is provided in the most appropriate setting without delay**”.

“On occasion a person may, for a range of reasons, decline to participate in the process of transferring them to the next stage of care” – for example, this could be concerns regarding the location of care and worries about receiving “ongoing rehabilitation and reablement care in a non-hospital setting such as a residential care home; previous negative experiences [or an] anxiety at moving to a different care setting”.

Understanding what matters to the person concerned “and why they are choosing to decline participation is key, though sometimes very hard to establish. The person needs to be fully informed not just on the next stage of care, but on the risks of remaining in hospital”[26].

[26] ‘The Management Of Reluctant Discharge / Transfer Of Care To A More Appropriate Care Setting Guidance’, NHS Wales.

Note: In cases where someone may not have sufficient mental capacity, the procedures outlined in section 7.5 above would need to be followed. The rest of this section is information relevant for situations where someone with mental capacity to make their own decisions doesn't wish to be discharged from hospital.

The role of the care coordinator

The wider role of the care coordinator is detailed in section 7.2 above. The 'reluctant discharge' guidance stresses their importance in situations where people may be worried, apprehensive, or not wish to leave hospital. The care coordinator should:

- "seek to ensure that communication channels remain open and effective". This should involve the patient themselves and also their family and carers, where applicable;
- "seek to consider any alternative options that the person and/or their family/carers may find more acceptable that would provide an appropriate alternative care setting"[27].

Potential consequences if the situation cannot be resolved

If further engagement between the care coordinator and the patient is unable to resolve the situation and lead to a successful discharge from hospital then, ultimately, the Local Health Board (LHB) may seek legal advice to proceed with the discharging process (this should only ever be a last resort, however). **If you are faced with this situation, seek advice as soon as possible** – see below.

If the LHB wishes to proceed with discharge in these circumstances, then a "relevant and appropriate [LHB] executive manager" must give the go ahead. The local authority social worker of the person concerned must also be "informed of and aware of the planned approach"[28].

If you are being discharged against your will – seek advice

If you are faced with this situation, the following may be options:

[27] Ibid
[28] Ibid

- **Advocacy** – an advocacy service might help if you feel your voice is not being heard. See section 8 above for further information on finding advocacy in your area.

  The 'reluctant discharge' guidance stresses that "any specific or exceptional considerations of the individual's circumstances that may indicate it is inappropriate to continue to enforce the discharge [must] have been considered" before the LHB undertakes the 'last resort' action outlined above.

  Therefore, as an example, an advocate might be able to assist you to raise any specific and/or exceptional circumstances that you felt were not being taken into account by staff (or if you felt your needs might have changed or increased again meaning discharge might not be appropriate).

- **NHS complaints procedure** – you could make use of the NHS complaints procedure. It should be noted that initiating this procedure would be unlikely to delay the discharge actually taking place if a case had reached a certain level of seriousness and if the range of professionals and staff involved believed that the "discharge/next stage of care arrangements remain[ed] appropriate and safe"[29]. Further information can be found in Age Cymru's Factsheet 66w *Resolving problems and making a complaint about NHS care in Wales*.

Note: You could potentially seek legal advice as well, but be mindful of the cost of doing so. Ultimately, you may need to accept that you will need to go ahead with a discharge from the hospital, given that people don't have a right to occupy a hospital bed indefinitely (and when clinically ready, people are expected to move to a more appropriate care location).

15 Discharge procedures if your hospital treatment is via a private healthcare company rather than the NHS

You may have decided to opt for planned treatment or an operation to be carried out in a private hospital (either through an insurance plan, or meeting the cost outright).

[29] Ibid

Any private hospital will have its **own** discharge procedure and the consultant should be able to provide information, or ensure you receive it.

When you discuss and agree treatment options, ask if you are likely to be able to manage personal care or other daily tasks on returning home.

You could also ask if, following the operation, you might benefit from aids to help with mobility to ensure your safety and what post-discharge support the hospital provides.

Your right to an assessment from the local authority social services department

You still have a right, as would an NHS patient, to an assessment from social services once they are aware that you may need social care services – i.e. the right applies regardless of who funds your hospital treatment.

However, as social services staff are not based in private hospitals, having an assessment can present practical problems. It is therefore helpful to contact your local authority social services department as soon as your admission date is confirmed. Explain the kind of support the consultant says you might need and for how long. This could indicate if your needs are likely to meet national eligibility criteria for care and support.

Further information on care needs assessments from the local social services department can be found in Age Cymru's Factsheet 41w *Social care assessments for older people with care needs in Wales*.

16 Disputes and complaints in regard to hospital discharge arrangements

16.1 Complaints regarding the NHS

Age Cymru's Factsheet 66w *Resolving problems and making a complaint about NHS care in Wales* has further information on this topic.

You could also seek advice and/or support from Llais – see section 17 below for contact details.

16.2 Complaints regarding social services

Age Cymru's Factsheet 59w *How to resolve problems and make a complaint about social care in Wales* has further information on this topic.

You could also seek advice and/or support from Llais – see section 17 below for contact details.

16.3 Complaints involving both the NHS and social services

Because of the way that NHS and social services functions frequently overlap when arrangements are being made for hospital discharge, you may be unhappy with elements of your care planning and/or services provided by both organisations.

In these cases, the NHS and local authority social services departments have a **duty to co-operate**.

If either of the two receives a complaint that involves both organisations, they must approach the other one and agree who will:

- take the lead in handling your complaint;
- be your point of contact and take responsibility for communicating with you;
- co-ordinate the handling of the complaint and any investigations;
- ensure you receive a single response, addressing all issues agreed at the outset.

16.4 The Public Services Ombudsman for Wales

The Ombudsman can be contacted in regard to complaints involving the NHS and/or social services.

Usually, you will have had to go through their complaints procedures **first**, but if you remain unsatisfied you can escalate the case to the Ombudsman – see section 17 below for contact details.

16.5 The Healthcare Inspectorate Wales (HIW)

HIW is the independent inspector and regulator of all healthcare in Wales. This includes independent healthcare providers, as well as NHS services.

HIW have responsibility for ensuring that all providers of health services in Wales meet required quality and safety standards.

Although HIW is **not** required to investigate individual complaints, they are interested in making a record of any concerns or complaints that people have, so that they may monitor these to help form an overall picture of trends in health services – for example, in quality and safety. As a result, they may investigate issues that suggest wider or continuing failings within the NHS.

Contact details for HIW can be found in section 17 below.

16.6 The Care Inspectorate Wales (CIW)

The CIW is the body responsible for inspecting, regulating and maintaining standards in social care services in Wales. The CIW does not have a duty to respond to you individually in the same way as a local authority complaint. What they will do, however, is record your concerns which may then be used to inform their work of maintaining overall standards. Contact details can be found in section 17 below. There is also some further information on the CIW in Age Cymru's Factsheet 41w *Social care assessments for older people with care needs in Wales*.

16.7 The Equality Act 2010 and health treatment for older people

Under the *Equality Act 2010*, it is not lawful for doctors – without good and sufficient reason – to suggest or provide inferior treatment (or refuse to provide treatment at all) solely because of your age.

Whilst age can play a part, staff should take into account your 'biological' age (how well your vital organs and systems are working) and not simply base services on your 'chronological' age (your age in years).

As well as the NHS, the act also applies to other public bodies, including local authorities and their various departments such as social services. Under the *Equality Act 2010* age is one of a number of 'protected characteristics'. Public bodies must ensure they don't discriminate in relation to these. The other characteristics, in addition to age, are:

- disability;
- gender reassignment;
- marriage and civil partnership;
- pregnancy and maternity;
- race;
- religion or belief;
- sex; *and*
- sexual orientation.

For further information on the Equality Act, see Age UK's *Factsheet 79 Equality, discrimination and the Public Sector Equality Duty*.

The **Equality Advisory & Support Service** website may also be helpful. See section 17 below for contact details.

16.8 Human rights legislation – the Human Rights Act 1998

The *Human Rights Act 1998* underpins the interpretation of all other legal obligations for the NHS and local authority social services departments. As such, human rights principles can be used to promote better care for people.

There is a duty on all public authorities – such as an NHS hospital or a local authority – to uphold the *Human Rights Act*, which contains the articles listed below (not an exhaustive list).

Human Rights:

- "Belong to everybody – whatever their age".
- "Are based on fairness, equality, dignity and respect".
- "Mean that the state must not unlawfully interfere or allow interference with rights, for example by treating people in an inhuman or degrading way"
- "Require the state to act to protect rights, for example, to protect life"[30].

[30] Protection of older people in Wales: A guide to the law, Older People's Commissioner for Wales (3rd edition), November 2019.

Articles

- **Article 2:** *Everyone's right to life shall be protected by law*.
- **Article 3:** *No one shall be subjected to torture or to inhuman or degrading treatment or punishment*.
- **Article 5:** *Everyone has the right to liberty and security of person*.
- **Article 8:** *Everyone has the right to respect for their private and family life, home and correspondence*.
- **Article 14:** *The enjoyment of the rights and freedoms in the European Convention on Human Rights shall be secured without discrimination on any ground (including discrimination on the grounds of age)*.

Further information

The Equality Advisory & Support Service can advise on issues relating to equality and human rights – see section 17 below for their contact details.

16.9 Case studies where a human rights approach has been used in a dispute or complaint

Case study 1 – how human rights may be relevant in social care services following a hospital stay

"A disabled woman was told by her occupational therapy department that she needed a special ('profile') bed. She was unable to leave her bed and this new arrangement would allow carers to give her bed baths. She requested a double bed so that she could continue to sleep next to her husband. The authority refused her request even though she offered to pay the difference in cost between a single and double bed. A stalemate ensued for eighteen months until the woman was advised by the disability law centre to invoke her right to [respect for their] private [and] family life."

Outcome: "Within three hours of putting this argument to the authority it found enough money to buy the whole of her profile double bed"[31].

[31] Passing the Baton: A Practical Guide to Effective Discharge Planning, NHS Wales, 2008.

Case study 2 – using a human rights approach in regard to how care can be provided

"An older woman was staying in hospital following a number of strokes. She had been interned as a Japanese prisoner of war during the Second World War and suffered a range of trauma related mental health problems. She [had previously been] observed re-enacting various behaviours from this period including washing her clothes with rocks". Against her wishes, "the hospital sought to discharge her and move her into residential care on cost grounds".

An advocate acting for her "was concerned that being in an institution was what was causing this regression. He used human rights language to argue that she should not be placed in residential care and that she be allowed to return home in accordance with her wishes".

Outcome: "Funding was secured to support her care at home"[32].

17 Useful organisations

Age Cymru Advice

Free and confidential information and advice on matters affecting the over 50s in Wales.

Tel: 0300 303 44 98

E-mail: advice@agecymru.org.uk

Website: www.agecymru.org.uk/advice

Age Cymru organisations (local)

Your local Age Cymru may be able to provide advice and support on a range of issues. **Age Cymru Advice** can provide details of your local Age Cymru (see above), or visit the Age Cymru website at:

www.agecymru.org.uk/local

[32] Ibid

Alzheimer's Society

Provides information and factsheets about all types of dementia. They may also operate services in your area to support people with dementia, along with their families and carers.

Tel: 0333 150 3456
Website: www.alzheimers.org.uk

British Red Cross (The)

Offer a range of services, such as disability equipment and wheelchair loans, domiciliary care, home from hospital support and transport services. Some services may only be available in certain geographical areas.

Tel: 0344 871 11 11
Website: www.redcross.org.uk/get-help

Care Inspectorate Wales (CIW)

CIW inspects and regulates care and social services in Wales.

Tel: 0300 7900 126
E-mail: ciw@gov.wales
Website: www.careinspectorate.wales

Carers UK

A national charity providing information, advice and practical and emotional support for carers.

Advice Line: 0808 808 7777
E-mail: advice@carersuk.org
Website: www.carersuk.org/wales

Citizens Advice Bureaus (CABs)

National network of free advice centres offering confidential and independent advice, face to face or by telephone.

Tel: 0800 702 2020

Details of your nearest CAB can be found at:

www.citizensadvice.org.uk/wales

Department for Work and Pensions

Contact numbers for the following benefits are listed below, or you can visit the GOV.UK website:

www.gov.uk/disability-benefits-helpline *(for disability benefits)*

www.gov.uk/carers-allowance-unit *(for Carer's Allowance)*

Attendance Allowance: 0800 731 0122

Disability Living Allowance: 0800 121 4600

Personal Independence Payment: 0800 121 4433

Carer's Allowance: 0800 731 0297

Equality Advisory & Support Service

A helpline that can advise people on equality and human rights issues.

Tel: 0808 800 0082
Website: www.equalityadvisoryservice.com

Healthcare Inspectorate Wales (HIW)

The HIW is the independent inspector and regulator of NHS healthcare and independent healthcare organisations in Wales.

Tel: 0300 062 8163
E-mail: hiw@gov.wales
Website: www.hiw.org.uk

Llais

A body that represents the voices and opinions of people in Wales in regard to health and social care services.

Tel: 029 20 235558
E-mail: enquiries@llaiscymru.org
Website: www.llaiswales.org
Contact details for your local Llais team: www.llaiswales.org/in-your-area

Macmillan Cancer Support

Offer a range of support for people affected by cancer, their carers and family. Macmillan Cancer Support fund nurses and other specialist health care professionals and operate cancer care centres. They also support cancer support groups across the UK.

Tel: 0808 808 00 00
Website: www.macmillan.org.uk

Marie Curie

A charity that is dedicated to the care of people with any terminal illness, as well as offering support to family members.

Tel: 0800 090 2309
Website: www.mariecurie.org.uk

NHS 111 Wales

NHS 111 Wales can provide contact details for local services and telephone or web advice on health issues and common illnesses.

Tel: 111
Website: www.111.wales.nhs.uk

Older People's Commissioner for Wales

Independent champion for older people across Wales.

Tel: 03442 640 670
E-mail: ask@olderpeople.wales
Website: www.olderpeople.wales

Public Services Ombudsman for Wales

The Ombudsman looks to see whether people have been treated unfairly or have received a bad service from a public body, such as a local authority.

Tel: 0300 790 0203
E-mail: ask@ombudsman.wales
Website: www.ombudsman.wales

Royal Voluntary Service (RVS)

RVS operate various services in Wales to help older people stay independent at home.

Website: www.royalvoluntaryservice.org.uk

Welsh Government

The devolved government for Wales.

Tel: 0300 060 4400
E-mail: customerhelp@gov.wales
Website: www.gov.wales

18 Further information about Age Cymru

18.1 Who we are

Age Cymru is the national charity for older people in Wales. We work to develop and deliver positive change with and for older people.

Together with our local partners:

- we provide information and advice;
- we deliver wellbeing programmes;
- we provide independent advocacy;
- we support carers;
- we campaign and research.

Age Cymru

Mariners House
Trident Court
East Moors Road
Cardiff
CF24 5TD

029 2043 1555

www.agecymru.org.uk

18.2 How we can help

Age Cymru Advice: our information and advice service for matters affecting people over 50 in Wales

Age Cymru Advice is committed to being the foremost information and advice service to older people in Wales. We aim to provide effective, accessible, high-quality information and advice while offering a free, impartial and confidential service. Age Cymru Advice can assist older people themselves, their family, friends, carers, or professionals. All of our guides and factsheets are available to download from our website, or you can contact our advice line to have copies posted to you for free.

Local support

Age Cymru Advice also acts as a gateway to our local services. Face to face support via local offices and home visits may be available to people requiring additional or more specialised support.

Getting in touch

If you want to talk to one of our expert advisers, in Welsh or English, call us on **0300 303 44 98**. Our advice line is open between 9am and 4pm, Monday – Friday.

(Calls are charged at the same rate as a call to a standard 01 or 02 number. They will also be automatically included in any landline or mobile inclusive minutes package).

You can also:

- email us at **advice@agecymru.org.uk**; *or*
- visit our website at **www.agecymru.org.uk/advice**

Gwasanaeth Cwbl Achrededig sy'n cynnwys adolygu gan gymheiriad
Fully Accredited Service with peer review

IAQF Cymru Wales
Llywodraeth Cymru Welsh Government

darparu gwybodaeth a chyngor o safon i bobl Cymru a hynny mewn modd sy'n gyson
providing a consistent approach to quality information and advice for the people of Wales

Helplines Partnership Member

advice quality standard

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Sign up to our newsletter

Our quarterly newsletter contains details of our campaigns, services and how you can support our work. Sign up today by visiting:

www.agecymru.org.uk/agematters

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18.3 How you can help

All the information and advice we provide is free and completely impartial. In many cases our timely intervention can be life changing. We are an ageing population and more people than ever are coming to us for support. You can help us be there for those that need us most.

Make a donation

No matter how small or large, donations make a massive difference and help us continue our important work.
Call: **029 2043 1555**
Visit: **www.agecymru.org.uk/donate**

Every donation we receive helps us be there for someone when they need us.

- £10 helps towards a fully trained expert advice worker to respond to queries from people who need the support of our information and advice service.
- £20 helps towards the cost of us producing free information guides and factsheets that provide useful advice on issues affecting people over 50.

Fundraise

Whether it is having a bake sale, running a marathon or knitting small hats for the Big Knit, there are so many ways to raise vital funds to support our work.

Call: **029 2043 1555**
Visit: **www.agecymru.org.uk/getinvolved**

Volunteer with us

All volunteer roles at Age Cymru support us to improve lives. However you'd like to get involved, we'd love to hear from you.

Call: **029 2043 1555**
Visit: **www.agecymru.org.uk/volunteer**

Leave us a gift in your will

With a gift to Age Cymru in your will, you can do so much to make sure older people have the support they deserve in the years to come. Leave a world less lonely.

Call: **029 2043 1555**
Visit: **www.agecymru.org.uk/legacy**