NHS
Ashford and St. Peter's Hospitals
NHS Foundation Trust

Patient Information

Admission and Discharge Information

Name of Patient: .....

Ward: ..... Phone: .....

Contents

Chief Nurse's Welcome

Welcome to Ashford and St Peter's Hospitals NHS Foundation Trust

I hope you and your loved ones and carers will find the enclosed information useful. We are very proud of the Team at Ashford and St Peter's Hospitals and aim to always provide a high-quality service for our patients.

We shall do our best to make your care episode as safe and effective as possible and of course treat you with compassion, dignity, and respect.

We welcome comments and feedback both positive and suggestions for improvement you would like to share with us. Listening to our patients helps us to get things right.

Ellen Bull
Interim Chief Nurse

Planning your discharge or transfer from hospital

Introduction

This booklet aims to give you support and information about your discharge from hospital. It should provide you with all the information you need to ensure you are prepared for leaving hospital.

Please read this booklet on admission, so that you can be fully involved in all aspects of your discharge.

Hospitals are the right place to be when you need specific medical or surgical treatment. However, once your treatment is completed, it is important that your discharge is not delayed, this is because:

- Some people find it harder to return to their usual residence the longer they stay in hospital.
- Staying in hospital for longer than needed increases the risk of acquiring an infection.
- Beds are needed for people who require emergency admission or are waiting for surgery.

After reading this booklet, if you have any further questions or worries about your discharge, please do not hesitate to contact the Ward Manager or Matron who can be contacted via the ward staff.

Your nurse will provide you with the telephone number for your ward which you can share with your Next of Kin (NOK). If you need to contact the Complex Discharge Team, please call 01932 723591 Mon-Fri 9am-6pm or via the switchboard 01932 728000 at weekends 8am-4pm.

The Trust and your care team wish you well for the future.

Planning for Discharge

- **What happens when I am first admitted to hospital?**

  You will be admitted to a specialist area where you will receive treatment for the condition that brought you to hospital. Here you will meet your doctor and other members of the ward team who will work with you and your NOK to plan your discharge from hospital while you are recovering. This will help to keep your stay in hospital as short as possible and to ensure a smooth discharge.

  At this early stage, you will be advised of when your Expected Discharge Date is likely to be. This is the date by which we expect your medical treatment to be complete. Although this date may change, it really helps to have a date that you, your NOK, and the staff can work towards to ensure a safe and timely discharge.

- **During Your Hospital stay**

  Once you have been admitted to the ward, you will continue to receive your treatment as well as being cared for by the ward nurses. This would be a good opportunity to inform the ward of any issues that could delay your discharge from hospital. If the ward identifies that you may require additional support on discharge then you will be referred to an Occupational Therapist or Physiotherapist to assess your daily function and/or mobility to determine what care if any, needed to support you at home. If care is required to support you on discharge, then you will be referred to the Adult Social Care Team or the Complex Discharge Team who will coordinate your discharge with you and your NOK.

- **Transfer of care**

  Once your ward Consultant has deemed you medically ready for discharge, you will be expected to leave the hospital in a timely manner. However, there may be a delay in getting you home due to needing large hospital equipment, large packages of care or you may now need a placement. At this stage you will be expected to

be transferred and moved to one of our step-down areas. This could be on another ward in the Trust, at one of the Community Hospitals or at one of our Block Contract Beds (BCB) located at three local nursing homes. The reason you will need to go to one of these step down beds is due to the ongoing daily demand for our Acute beds who are required for our sick patients. The Trust really appreciates you and your family's cooperation with these moves. In agreeing to these moves enables our A&E Department and the hospital to maintain flow to ensure that we are freeing up our valuable Acute beds to those who really need them and avoids a delay in their treatment.

- **Rehabilitation**

If you are assessed by the Physiotherapist as meeting the criteria for inpatient Rehabilitation you will be referred to a community hospital for a period of rehabilitation. We will try to transfer you to the community hospital as near as possible to your home, but we cannot always guarantee this. It is vitally important for you to continue your rehab in the community hospitals, wherever the bed is available. Due to the high demand for rehab beds, you may be placed on a waiting list until one becomes available.

- **Block Contract Beds (BCB)**

Our Block Contract Beds (BCB) are located at three nursing homes which are Abbey Chase (Chertsey) White Gates (Laleham) and Kings Lodge (West Byfleet). The Trust works closely with each of these nursing homes to support patients who are medically ready to leave the hospital but cannot immediately return home for various reasons. Patients who are identified by our Adult Social Care team colleagues as requiring this service will be referred to BCB. This service is free of charge for up to a maximum of four weeks while the team work with you to help you recover and determine the long term plans for your discharge and destination. The Adult Social Care Team in the BCB nursing homes will work with you and

determine if you are eligible for further support from Surrey County Council or if you will need to pay for your own care depending on your financial status. For more information on this service please see separate leaflet on Short-term support in a care home setting.

- **What if I cannot manage at home and need to consider alternative options?**

  It can be an emotional and anxious time going home, particularly when you have spent some time in hospital, but once home, patients often find they feel more settled and more able to help themselves in their own environment with friends and family around them. Please note that funding has now changed and that the six-week NHS funding is no longer available and that no long-term assessments are carried out in Hospital. If you are deemed as requiring support on discharge, you may not need to fund this yourself. This will be based on whether you have savings above the Capital Threshold of £24,500. However, if you do fall below the Capital Threshold you will be referred by the ward to the Hospital Adult Social Care Team for an assessment of your needs and they will be able to support you with the care that you need. Continuing Health Care (CHC) assessments no longer take place in hospital, if you meet the criteria for assessment, you will be discharged from hospital under the CHC Discharge to Assess Pathway and CHC will continue to assess your needs in the community. If you meet the criteria for a Fast Track (having a rapid decline or entering a terminal phase) this assessment will be carried out during your stay in the hospital. If CHC deems there is clinical evidence to support your Fast Track, then CHC will lead and support your discharge out of hospital.

  For further information on the changes to funding your care, please ask to speak with a member of the Complex Discharge Team.

- **Integrated Discharge Unit –** This is a Team made up of a group of professionals from Health (Complex Discharge Team), Adult Social Care Team (ASCT), Central Surrey Health who provide a Rapid Response Service such as nursing and therapy care in the community and ASCT provides a Reablement service which offers support and assessment on discharge. These teams are co-located both in the community and at Ashford and St Peter's Hospital. They work collaboratively together to support the safe and timely discharge of our patients.

- **Complex Discharge Team –** The role of a complex discharge coordinator is to facilitate the discharge process, particularly when it comes to more complex cases. The Complex Discharge Team are an experienced team who deal with complex discharges. It is important to remember that all staff, patients, and their families / carers play a part in ensuring a smooth and efficient discharge. If you have any questions or concerns about discharge, please speak to the Complex Discharge Team on 01932 723591.

- **Self-funders -** Social care is not free to everyone. Therefore, if after completing a financial assessment with Adult Social Care (Surrey County Council) or you inform the ward team that you have savings above the Capital Threshold of £24,500, then you will be identified as a self- funder. If at this point you need care on discharge, then you will be referred by the Ward or the Adult Social Team to the Private Funders Officers. The Private Funders Officers are part of the Complex Discharge Team and are based within the hospital. They can support you and or your family to organise a package of care, a live in carer, respite, or longer-term placements to support your discharge from hospital. You can contact them directly on 01932 726361/01932 726598

- **Adult Social Care Team (ASCT) –** The Adult Social Care Team supports patients and carers who have longer-term and complex needs that prevent them from doing routine things each day. They

can also provide short term support to help you get back to full fitness or mobility after a hospital stay or if you are recovering from a mental illness. If we find you need our support, we can speak to you and find out about the areas that matter to you and would make the greatest impact on your life and wellbeing. You then have the option to choose the support that will allow you to achieve the goals that matter most to you. We aim to help people to stay independent, preferable in their own home for as long as possible. Anyone who thinks they may need support can ask us to carry out an assessment which will take place in the community.

- **Reablement Team -** If you have been assessed by the Occupational Therapist / Physiotherapist as needing short term/ skills gain program on discharge then you will be referred to this service. This is a short-term service that is offered to patients who require support in their own homes on discharge from hospital. This is free at the point of service.

  Adult Social Care Team in Surrey provides a Reablement service that helps you to learn how to accommodate your illness or condition and remain independent at home. Our specially trained staff will assess your needs and support you to learn or relearn the skills necessary for daily living. Your progress will be monitored on an ongoing basis. You may only need as little as a few days to regain your skills or perhaps longer, up to a **maximum** of six weeks. If, after the Reablement period you have been assessed as requiring on-going support, the Reablement team will send recommendations to the appropriate Adult Social Care Team. If you are assessed as being 'self-funding' the team can support, you to arrange private ongoing care via a domiciliary care provider.

- **Rapid Response –** If you are assessed by the Physiotherapist as requiring physiotherapy or an environmental check in your home on discharge then you will be referred to Rapid Response Team who will again offer short term/skills gain program to individuals who need that further support on discharge.

- **Transport home –** Hospital transport can only be provided for patients who have a medical need. If you are not in this category, please make sure you have informed a relative or friend that you are for discharge, so they can arrange transport on your behalf. If you are being transferred out of the area and do not have a medical need, you will be expected to pay for transport. The Trust can obtain competitive quotes if required.

- **Day of Discharge and medication** – On the day of discharge, we expect your bed to be vacated where possible by 10 am. This is to give ward staff time to clean the bed space and be ready for the next patient. A trained nurse will provide you with any new medication you may need to take home and they will explain this to you. You will be given a copy of your discharge letter. This will also be sent electronically to your GP. You will be supplied with a supply of medication on discharge. Thereafter your GP will supply these to you. Any medication brought in on admission will be returned to you on discharge.

  Any referrals to the District Nurses will be made by the ward staff and you will be also given a copy of this referral. Any dressings, catheter bags etc. will also be arranged by the ward staff for you to take home if needed. Any existing or restarts of packages of care whether with Adult Social Care Team/ Privately Funded or through Continuing Health Care will be restarted for the day of discharge. It is important that you have some outdoor clothes brought in for your journey home. The ward staff will liaise with you, your family/carer or friend to confirm that you will be discharged that day.

- **Checking that everything is ready at home.**
  - ☐ Do people know you are coming home? Can they collect you?
  - ☐ Do you have a key? Key Code?
  - ☐ Have you got sufficient food in the house?
  - ☐ Is the heating turned on?
  - ☐ Medication given to take home?
  - ☐ Discharge Letter given?

- **What help is available for carers?**

  Each ward holds information about local services to carers. However, if you are the main carer, we can refer you to the Community Adult Social Care Team for a carers assessment. This assessment is your opportunity to talk about your own needs and things that could make caring easier for you. These assessments are undertaken by a social care practitioner and can look at the support available from a range of organisations, e.g., services that give you a break or time to yourself, a direct payment for a service to support you as a carer, emotional support from other carers or from a local Carers Support Scheme, help with caring or household tasks and back care advice. If you provide care to a friend or relative for 35 hours or more each week, you may be entitled to carer's allowance. The social care practitioner for the ward can provide further information on how to claim this allowance. We also recommend that you register with your GP as a carer as this will ensure your GP routinely considers the impact your caring role may be having on your own health. Your GP will provide the appropriate registration form.

- **Housing and Homelessness -** If you are homeless or facing eviction from your current home it is important that this is disclosed on your admission to the hospital. The Complex Discharge Team will liaise with District and Borough Councils about your case. We will work with the local council to support you and try to provide temporary accommodation, but this will be based on an assessment by the Council team. If you can stay with friends or family temporarily but have housing needs, we can still alert the Council teams of your behalf. If you should need any further information on Hostels / Shelters, please ask to speak to the Complex Discharge Team who can provide contact details of all the local Hostels / Shelters.

After discharge - useful information

Services provided by the borough councils: Homesafe Plus

- **Community alarm -** help provided day or night at the touch of a button, via either a “necklace” or wrist bracelet. Friendly staff will call out the emergency services, GP, friends/relatives, as appropriate.
- **Handyperson Scheme -** helps with small jobs around the home that are difficult to do and minor aids, such as grab and stair rails, to prevent accidents. Available in the private sector for people aged 65 plus.

NB: Age limits do vary across authorities, so if you are under 65 check to see if you qualify.

- **Sheltered Housing –** safe secure accommodation with support from staff. This service is provided either by the Borough Council or local registered social landlords.
- **Community Centers -** provide social plus recreational activities and events and promote health and wellbeing.
- **Dial a Ride/Community Transport -** accessible door to door transport for individuals who have difficulty accessing other public transport services.

For further information contact the Borough Councils:

Woking: 01483 755855
www.woking.gov.uk

Elmbridge: 01372 474552
www.elmbridge.gov.uk

Spelthorne: 01784 451499
www.spelthorne.gov.uk

Runnymede: 01932 425868
www.runnymede.gov.uk

Other useful telephone numbers:

Meals on Wheels frozen or hot meals providing a daily/weekly delivery	
Elmbridge	**01372 474552**
Runnymede	**01932 425010**
Spelthorne	**01784 444265**
Surrey Heath	**01276 707657**
Woking	**01483 770777**
Feltham & Hounslow	**0208 577 5496**

Social Services	
Hounslow	**0208 583 3100**
Richmond	**0208 8917971**
Surrey	**0300 200 1005**
West Berkshire	**01635 503050**
Windsor & Maidenhead	**01628 683744**
Feltham & Hounslow	**0208 577 5496**

Pharmacy Medicines Helpline	
Open Monday to Friday 09:00 to 17:00 Please have your medicines to hand when you make the call.	**01276 604744**

- **Safe driving –** It is possible your condition may temporarily affect your fitness to drive. Please check this with your doctor. It is advisable to check with your motor insurance company, as you may find that a set period is required before you are able to drive and, if you disregard these conditions, your insurance cover would become invalid.

- **Transport –** A few local transport services are available if you cannot drive:

Name of service	Type of service	Contact details
Dial a Ride (Elmbridge)	An accessible transport service for Elmbridge residents of any age with a mobility problem.	**01372 474944**
Spelthorne Volunteer Drivers	A registered charity (1084841) helping the elderly and infirm residents of Spelthorne get to their medical appointments.	**07817 926736**
Woking Shop mobility	Hire scheme for people with disabilities and elderly.	**01483 776612**

Name of service	Type of service	Contact details
Woking Bustler Dial a Ride	Door to door transport service for residents of Woking Borough who have mobility issues.	**For bookings: 01483 757 115** **For advice: 01483 744 800** enquiries@woking_bustler.org.uk
White Bus 446 bus service - staff and visitor transport	White Bus provide an extended public 446 bus service which runs from Woking Train Station to Hatton Cross and includes stops at St Peter's Hospital and Ashford Hospital, as well as Heathrow Terminal 4, and Hatton Cross Underground Station. The 446 service will run on Sundays and bank holidays but will not stop at Ashford Hospital.	To plan your journeys, please check the timetable. For tariff details and information on downloading the White Bus app, please go to the White Bus website for route 446. www.whitebus.co.uk/bus-services/446/

Other support:

Name of service	Type of service	Contact details
Action for Carers Surrey **Sam Caine Hospital Care Support Advisor (HCSA) Action for Carers**	Carers Surrey offer personalised advice, information, signposting and emotional support, via face-to-face meetings in the hospital, phone calls and events. They can bridge communication gaps between yourself and the hospital by advocating on your behalf and support and advise on processes such as MDT meetings and discharge process. They can make referrals to other partner agencies for a carers assessment.	**Carers Helpline 0303 040 1234** carersinfocenter@actionforcarers.org.uk www.actionforcarers org.uk **Sam Caine, HCSA 07989 402764** sam.caine@ actionforcarers .org.uk
Age UK (previously Age Concern and Help the Aged)	National organisation offering local support aimed at improving later life for everyone via information and advice, campaigns, products, training and research.	**0800 169 6565** www.ageuk.org.uk

Name of service	Type of service	Contact details
Alzheimer's Society	National organisation offering local services and information.	**Dementia Connect Support Line** **0333 150 3456** www.alzheimers.org uk
British Red Cross	National organisation offering local providing valuable short-term support to vulnerable people in the UK.	**0344 871 1111** www.redcross.org.uk
Homesafe Plus	Homesafe Plus tailors existing borough services to provide immediate support after discharge and, over the course of six weeks, will link patients to a variety of services available. **Community Alarm** **Community Meals** **Temporary Key Safe** **Home Assessment**	**01932 425865** **Mon-Fri 9am-5pm** **Out of hours** **01932 425060** www.runnymede. gov.uk/ wellbeing/ homesafe-plus
Medical Moves	This is a service that is available to those being discharged from hospital and / or requiring items relocated or removed to accommodate a new lifestyle.	**01483 346033** medicalmoves@ wokingcfp.org.uk

Name of service	Type of service	Contact details
Outpatient Transport	This is a service that provides Transport to Outpatient appointments.	**0300 1239840**
Samaritans	Whatever you're going through, you can call us any time, from any phone for FREE.	**Call us any time, day or night 116 123**
Social care and support guide	Free, confidential information and advice for carers, also providing local community support.	www.nhs.uk/conditions/social-care-and-support-guide/
Stroke Association	Providing information and community services to support people affected by stroke.	**0303 3033 100** www.stroke.org.uk
Veteran support	There are many support agencies available for the Armed Forces Community.	www.ashfordstpeters.nhs.uk/armed-forces-and-veterans
Your Sanctuary	Surrey-based charity which provides help and advice about domestic abuse situations between 9am and 9pm, 52 weeks of the year.	www.yoursanctuary.org.uk **01483 776822**

Additional details about our hospitals, including information regarding the department caring for you can be found by logging onto our website at **www.ashfordstpeters.nhs.uk**. The national NHS website, now known as NHS Choices at **www.nhs.uk**, also includes an A to Z guide to health.

Further Information

We endeavour to always provide an excellent service, but should you have any concerns please, in the first instance, raise these with the Ward Manager or Matron. If they cannot resolve your concern, please contact our **Patient Advice and Liaison Service** (PALS) on **01932 723553** or email **asp-tr.patient.advice@nhs.net**.

If you remain concerned, PALS can also advise upon how to make a formal complaint.

Author: Catherine Courtney-Grayson,
Complex Discharge Team Manager

Department: Complex Discharge Team

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Notes/Other information:

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We can provide interpreters for a variety of languages, information in larger print or other formats (e.g. audio) - please call us on 01932 723553.

You can use Text Relay to turn telephone communications into text.
Use the Relay UK app on your phone, tablet or PC.
You can also use Relay UK via Minicom or Uniphone.

اگر نیاز به ترجمه دارید، لطفا با شماره 01932 723553 تماس بگیرید.

ਜੇ ਤੁਹਾਨੂੰ ਤਰਜਮੇ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਇਸ ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ: 01932 723553

اگرآپ اس کااُردوزبان میں ترجمہ چاہتے ہیں، توبراہ کرم اس فون نمبر 01932 723553 پرابطہ کریں

Se precisa de uma tradução por favor contacte: 01932 723553

আপনার অনুবাদের দরকার হলে এখানে যোগাযোগ করুন : 01932 723553

यदि आपको अनुवाद की ज़रूरत है तो कृपया इस नंबर पर फोन करें: 01932 723553

Jeżeli chcemy, aby te informacje w innym języku, proszę zadzwonić 01932 723553

Ashford Hospital
London Road,
Ashford, Middlesex,
TW15 3AA
Tel: 01784 884488

St Peter's Hospital
Guildford Road,
Chertsey, Surrey,
KT16 0PZ
Tel: 01932 872000

www.ashfordstpeters.nhs.uk