Leaving hospital

Each hospital must have a discharge policy. This policy should make sure that patients have been assessed for any services they might need when they go home or that any services they were getting before have been reinstated. For example, it may be that after your illness you need someone to help you have a bath. In order to obtain this service you will need an assessment from a social worker or home care manager. You may have been receiving services from "meals on wheels" before you became ill. It is the hospital’s responsibility to ensure that your meals on wheels will start again when you go home. The hospital should ensure that you are not discharged before services have been arranged for you.

Every hospital’s policy should include details such as how the hospital will arrange the discharge of patients properly, for example, by ensuring patients have transport home from hospital and by taking extra care about discharging people home on Fridays and weekends.

Hospital discharge guidance states that patients have the right:

a) To **full information on their diagnosis** and the assessment of their health and social needs in preparation for discharge.

b) To be fully **involved in planning** their own discharge, together with a relative, carer or friend as appropriate.

c) For the discharge plan to start on or **before admission** where possible.

d) To **full information on the services available** in the community relevant to their care.

e) To **full information on short- or long-term nursing or residential care**, including financial implications.

f) To be given an appropriate **contact number** where they can get help or advice on discharge.

g) To be given a clear, legible **discharge letter detailing the support services** to be provided for them (where appropriate).

h) To **full information on health authority criteria for continuing care**.

i) To have the **discharge planning team to be available** as a point of contact to offer support and advice to patients, carers, statutory and voluntary agencies.
j) Information on advocacy and support.

k) To have access to the trust complaints procedure and any complaint regarding their discharge arrangements investigated and a full explanation given.

l) If still not satisfied, then to be given access to the health service commissioner.

Having an assessment in hospital

If, after a stay in hospital, you have a high level of care needs you may have a multi-disciplinary assessment. This will involve a meeting between a hospital consultant, nursing staff, and social services and possibly your GP or other community health services. At this meeting they will look at your care needs and decide what services you should have to meet these needs. If you do not have anywhere to live or if there are a lot of problems with your housing then the housing services may also be involved in your assessment.

Each health authority must have published criteria explaining who is eligible for this type of assessment. People with lower levels of care needs will have a more simple assessment.

After the multi-disciplinary assessment the consultant will decide whether or not you will be offered a continuing care bed in hospital or in a nursing home which the health authority will pay for. The consultant must base his or her decision on the needs that you have and also on the health authority’s eligibility criteria for NHS continuing health care. Each health authority will have different criteria but they must all be based on guidance given by the Department of Health. In most cases only people with very high care needs or people who need specialist treatment will be eligible for NHS funded care.

The consultant may decide that you need further rehabilitation or care before you are discharged. Again this will depend on whether your needs meet the health authority’s eligibility criteria for this type of care. Section 5 gives more information.

The consultant may decide that you do not fit the health authority’s criteria for NHS continuing care or rehabilitation. The social services will then be responsible for assessing your needs and you may be expected to pay for any services they offer. Sections 6, 7 and 8 give more details about this.

You and your relatives are entitled to written information at the time of your assessment, or perhaps in another format, eg Braille, if it would be more useful to you to receive it in this way. You are entitled to the following information:

If you have a carer, s/he is entitled to an assessment in his/her own right. The carer’s assessment should consider the following areas:

- Care giving tasks
- How to get help and advice
- Information about care workers
- Information about metal illness
- Involvement in planning of treatment and care
- Support for carers
- Relationships with the person being cared for
- Family and friends
- Money
The carer’s well-being

Risk and safety

Choice of care

Other issues the carer may raise

Emergency arrangements

The carer’s care plan should be attached to the patient’s assessment.

NHS-funded continuing care

If, after your assessment, the consultant decides you meet the health authority’s eligibility criteria for long-term care you will be offered a place in a hospital, or in other accommodation paid for by the health authority.

Each Strategic Health Authority will have its own criteria. They will only be responsible when a person’s primary need is for health care rather than accommodation. Each Authority’s criteria should include:

- Individuals whose care needs are so complex, intense or unpredictable that they need regular (in the majority of cases this might be weekly or more frequent) supervision by a member of the NHS multidisciplinary team, such as the consultant, palliative care, therapy or other NHS member of the team.
- Individuals who require the routine use of specialist health care equipment under supervision of NHS staff. This would include specialist breathing or feeding equipment.
- Individuals who have a rapidly deteriorating or unstable medical, physical or mental health condition and requires regular supervision by a member of the NHS multidisciplinary team.
- Individuals who are in the final stages of a terminal illness and likely to die in the near future.
- There will be a limited number of cases where the complexity or intensity of nursing or other clinical needs might mean that a person was eligible for continuing care even though they no longer need medical supervision. This should include people who are completely immobile or need constant supervision to prevent harm or injury (either unintentional or deliberate) to themselves or others.

NHS continuing care can be provided in hospital, a hospice, a nursing home or the person’s own home.

In some cases, where a person’s health and social care needs are easily distinguishable, the health authority may put in place a joint package of care where funding is split between the Health and Social Services. Details of Joint Care Packages should be found in the Strategic Health Authorities’ Criteria for Continuing Care.

Care for people with a terminal illness

The guidance stresses that health authorities have a responsibility to provide care for people with a terminal illness. This is sometimes called Palliative care. People who do not have very long to live should not be expected to leave hospital accommodation unless this is what they want. Government guidance says that
people who are likely to die in the near future should be able to
remain in NHS funded accommodation.

This accommodation might be a hospice rather than a hospital. Each health authority’s
policy will be different, and the guidance does not advise health authorities how to interpret
‘the future’. All patients and their relatives are entitled to full information about what they can
expect.

Rehabilitation and recovery – intermediate care

Intermediate care is designed to provide high-quality pre-admission and rehabilitation care to
older people to help them live as independently as possible by reducing preventable
hospitalisation and to prevent delays in moving people over 75 on from hospital.

Intermediate care should

- Be targeted at people who would otherwise face unnecessarily prolonged hospital
  stays or inappropriate admission to acute in-patient care, long term residential care
  or continuing NHS in-patient care
- Be provided on the basis of a comprehensive assessment, resulting in a structured
  individual care plan that involves active therapy, treatment or the opportunity for
  recovery
- Have a planned outcome of maximising independence and typically enabling
  patients/users to resume living at home
- Be time-limited, normally no longer than six weeks and frequently as little as 2 weeks
  or less
- Involve cross-professional working, with single professional records and shared
  protocols

Intermediate care does not include:

- Transitional care that does not involve active therapy or other interventions to
  maximise independence ie; for patients who are ready to leave hospital but are
  simply waiting for longer-term packages of care to be arranged.
- Longer-term rehabilitation or support services
- Rehabilitation that forms part of acute hospital care
- It is not suitable for people with unstable acute medical conditions.

Intermediate care services should generally be provided in community-based settings or in
the patient/user’s own home, but it may be provided in discrete step-down facilities on acute
hospital sites. The most common intermediate care services will be:

Rapid Response
A service designed to prevent avoidable hospital admission. Patients can be referred by
GP’s, Accident & Emergency Departments, NHS Direct or Social Services for short-term
24hr nursing/therapy support and personal care in their own home.

Hospital at Home
Intensive support in the patient’s own home, including investigations and treatment which
are above the level normally provided at home but do not necessarily require the patient to
be in a hospital. This may be used either to avoid admission to hospital or to enable earlier
discharge from hospital.
Residential Rehabilitation

A short-term programme of therapy and enablement for people who are medically stable but need a short period of rehabilitation to enable them to re-gain sufficient physical functioning and confidence to return safely to their own home. Stays will range from 1-2 weeks to 4-6 weeks, depending on the individual circumstances. Residential rehabilitation may be offered following a stay in hospital or by a GP, Social Services or Rapid Response Team following a full assessment to prevent unnecessary admission to hospital.

Paying for Intermediate Care

All intermediate care packages are to be provided free of charge to the user, whether they have been arranged by the Health Authority or Social Services.

The Government has allocated funds to the NHS which should be deployed from the pooled budgets they hold with Social Services. Even if Social Services instigate the intermediate care package (which should not be put in place without a medical assessment), they cannot charge the service user.

Moving to a residential or nursing home

- All patients should be assessed for a period of rehabilitation before any permanent decision on care options is made.

If, after your assessment, the consultant feels you no longer need care funded by the NHS, you may be assessed as needing a residential or nursing home. The local authority social services will be responsible for arranging this care. A care manager or social worker will look at your care needs - this is called a care assessment. They will also do a financial assessment. Depending on the level of your capital (including savings and property) you may be entitled to help from the local authority and social security benefits to pay for this care.

Local authorities must not routinely seek a third party top-up when placing a patient in residential/nursing care. They must first show that they have a home available at their standard funding rate. Guidance LAC(2004)20 states:

"Where an individual has not expressed a preference for more expensive accommodation, but there are not, for whatever reason, sufficient places available at a given time at the council's usual costs to meet the assessed care needs of supported residents, the council should make a placement in more expensive accommodation. In these circumstances, neither the resident nor a third party should be asked to contribute more than the resident would normally be expected to contribute and the council should make up the cost difference between the resident's assessed contribution and the accommodation's fees."

Care homes providing nursing care are expected to have, as part of the facilities they provide, some standard items of equipment for anyone needing them and for the safety of staff. These should include hoists, wheelchairs for occasional use, bath and shower seats and fixed items such as grab rails. All other items of equipment to meet the needs of an individual should be, or should have been, provided to the patient on the same basis as if they were living in a private house, applying the same criteria.

If you are assessed as requiring residential or nursing home care but your levels of income or capital prevent Social Services from funding your care, you should ask if you qualify for
NHS-funded nursing care payments. If you meet the criteria, these payments will be made direct to the home and your fees should be reduced accordingly. NHS-funded nursing care is not means-tested.

What happens if you do not want to move to a residential or nursing home?
If you have been assessed as needing a residential or nursing home and do not want to go, then the hospital and social services should work with you to explore other options. This may involve arranging for care services to be provided for you in your home. You may be charged for these services or they may be limited to what your local authority can provide within the resources it has available.

Receiving care at home
After your assessment you may be offered care at home. This could involve a wide variety of services and could include community health services as well as services from your local authority. Any health services you receive from the NHS will be free but you may be charged for services provided by your local authority. Each local authority has its own charging policy for home care which must comply with the fairer charging guidance (more details in Factsheet D in Appendix C) and you should be given details of this when you are offered services. These services could, for example, include help to have a bath or to get up in the mornings.

It is important that you and your relatives have the opportunity and time to consider the options open to you. You cannot be forced into a home against your will. (There are exceptional circumstances where people with health problems may be detained).

Respite care and short-term care
Health authorities can pay for respite care or short-term care for people who are looked after at home. Each health authority has its own eligibility criteria. You can find out more about respite care by asking your health authority for a copy of their eligibility criteria.

Local authorities can also arrange and pay for respite care for people looked after at home. While NHS respite care from the health authority is free, local authorities can charge for respite care and charges vary greatly around the country. You can ask the local authority to assess you for respite care services. You can also ask for information about their charging procedure.

Hospital travel costs
Hospital travel costs for NHS treatment are usually paid on the day of the appointment at the hospital. On arrival, you should tell the receptionist you are seeking a refund of travel costs. You may be entitled to travel costs if:

You are in receipt of income support or Job Seekers Allowance – you will need to present proof of your appointment and your entitlement to benefit.

You are on low income and have capital of less than £16,000 – Before your appointment, you will need to complete a HC1 form – available from your local Benefits Agency or NHS hospital (your GP may also have these forms). The HC1 includes an income and expenditure section which will be used to assess whether you are entitled to a refund of all your travel costs or a partial refund. You will receive a response within four weeks. If you are entitled to a full refund you will be sent a HC2 certificate. If you are entitled to a partial refund
you will be sent a HC3 certificate. On arrival at the hospital you should present the HC2 or HC3 together with proof of your appointment.

You are a War Pensioner and the treatment is for the pensionable disability – you should apply to the War Pensions Agency (0800 169 2277) for a claim form. The WPA will send you a certificate & claim form which should be presented at the hospital. The hospital will stamp the form which should be returned to the WPA within 12 months. The WPA will assess the amount of travel costs you are entitled to and will issue a refund.

Refunds after the date of hospital appointment
If you are unable to obtain a refund on the day of your appointment, you should ask the hospital for a HC5 refund claim form – the form tells you what to do.

Payments in advance of hospital appointment
If you do not have enough money to get to the hospital and do not qualify for ambulance service transport, you should ask the hospital to send the payment in advance. If you cannot get this in time, you may be able to get a crisis loan from the Social Fund at your local Benefits Agency.

What travel costs can be paid?
Travel costs can only be paid if they are “necessarily incurred”. This means travel by the cheapest means of transport available this is normally:

- Public transport fares
- The estimated amount of fuel used if travel is by private car or the equivalent public transport cost, whichever is less
- Contributions the patient may make towards a local voluntary car scheme
- Taxi fares only if there is no other way they can travel for all or part of the journey. You should check with the hospital first that they will pay taxi fares – if you are unable to use public transport it may be possible for them to arrange hospital transport instead.
- Escort’s travel costs only if there is a medical need for someone to travel with the patient.

Visitor travel costs
The hospital travel costs scheme cannot pay visitors costs. Visitors may be able to get assistance with travel costs from their local benefits agency if:

- They are visiting a War or MOD pensioner who is being treated for the disablement s/he is getting the pension for
- They are visiting a close relative and are getting income support – they may be able to get help from the Social Fund.