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| **PATIENT CHOICE, EQUITY AND FAIR ACCESS POLICY;** **BED BASED SERVICES**  |

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| **SUMMARY POINTS** |
| This policy defines how the organisation will manage choice throughout a patients inpatient stay with regard to discharge planning, particularly at the point that a patient no longer requires the level of care provided by the organisation. The organisation will make every effort to discharge patients to the destination of their choice but not to the detriment of equitable and fair access to services for all patients. Therefore where the destination of choice is not available the organisation will offer alternative providers or an interim alternative. |
| The overarching aim is to reduce delays in the appropriate transfer of care or discharge of patients, through early engagement and support, and the implementation of a fair and transparent escalation process  |
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| 26 Feb 14 | 1.1 |  |  |  | Draft to include alignment to Discharge Pathway policy, and changes to TOC letters. |
| 27 Feb 14 | 1.2 |  |  |  | Draft to include revised introduction |
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**APPENDIX 11 – CONTINUING HEALTHCARE LETTER**

1. SCOPE OF POLICY
	* 1. This policy is relevant to all inpatients who are required to choose a destination and/or care provider on discharge from hospital. The process applies equally to all patients irrespective of funding arrangements for on-going care. The formal stages of 4 and 5 apply to those patients where appropriate choices have been refused.
2. PURPOSE
	* 1. The purpose of this policy is to ensure that choice is managed fairly throughout the discharge planning process. This requires consistent and timely Multi Disciplinary Team (MDT) intervention across all bed-based settings as set out in this policy. Where choice has become a barrier to discharge and appropriate options have been refused, the organisation will follow the formal stages 4 and 5.
		2. To be effective there must be clear escalation processes when a patient’s choice delays their discharge from hospital longer than is clinically required. This escalation process may be cross-organisational and is set out in the Supported Discharge Pathway Operating Policy.
		3. This operational policy sets out a framework to ensure that:
* Hospital beds will be used appropriately and efficiently for those requiring bed based care.
* When patients no longer need bed based care they will not remain in hospital if the preferred option is unavailable.
	+ - * Planning for effective transfer of care, in collaboration with the patient, their representatives and all members of the MDT will begin at or before admission but no later than 36 hours after admission.
			* The process of offering choice of care provider and/or discharge destination will be followed in a fair and consistent way throughout the Trust and there will be an audit trail of choices offered to patients.
			* Where a patient is unable to express a preference, an advocate will be consulted on their behalf.
1. DEFINITION
	* 1. This is a policy to support timely effective transfer of care of patients ready for discharge to the most appropriate setting.
2. aSSOCIATED DOCUMENTS
* Supported Hospital Discharge Pathway Operating Policy
	+ - * Achieving timely discharge from hospital. Department of Health (2004)
			* Discharge from hospital: pathway, process and practice. Department of Health (2003)
1. GLOSSARY
	1. **CQC**: Care Quality Commission
	2. **Discharge Process**: Transition planning for the patient’s discharge from a bed based healthcare service
	3. **EDD:** Estimated date of discharge.
	4. **IMCA**: Independent Mental Capacity Advocate
	5. **LA**: Local Authority
	6. **MDT**: Multidisciplinary team of health and social care professionals involved in the care and assessment of patients.
	7. **CCG**: Clinical Commissioning Group
	8. **Representative**: In this paper this is taken to mean the patient’s family, next of kin, advocate or other named representative.
	9. **Self funder**: A person who financially meets the full cost of their social care needs, whether because their financial capital exceeds the threshold for Adult Services funding or because they or a representative choose to pay for their care.
	10. **Social Care Assessment**: Under the Community Care Act (1990) all adult patients are entitled to an assessment of their social care needs.
	11. **SW**: Social worker or care manager Adult Services.
	12. **Social Work support**: Social Work teams based in the hospital will offer support to patients, regardless of financial status, to identify a suitable care home or package of care and to assist with discharge from the hospital setting. The only exceptions are Continuing Health Care (CHC) patients who are not known to Social Services; they will be supported by CHC.
2. MANAGING CHOICE
	* 1. The consequences of a patient who is ready for discharge remaining in an hospital bed are that:
			+ The patient is exposed to an unnecessary risk of hospital-acquired infection
			+ Frustration and distress may be caused to patients and/or their relatives whilst waiting for a preferred discharge destination to become available.
			+ The needs of the person can be more appropriately met in a lower-acuity setting, including a non-hospital environment
			+ Decrease level of patient independence, as a bed based environment is not designed to meet the needs of people who are medically well.
			+ Increased pressure within the Health care system due to the unnecessary use of hospital beds.
		2. The organisation will acknowledge and offer support with any concerns, whether financial or otherwise, whilst reinforcing the message that each member of the MDT will work towards discharge, at the end of the period of care, to a safe destination. This destination may not be the patient’s preferred destination of choice.

6.3 At the point at which a patient is ready for discharge or transfer of care as decided by the MDT they cannot continue to occupy a hospital bed. The MDT update of Clinical White Board will happen once a day in Community Hospitals and twice a day in the Acute setting.

6.4 If the patient preferred choice is not available they will be required to accept an alternative location or care provider whilst they await availability of their preferred choice

6.5 People who are self-funding their care will be provided with the same advice, guidance and assistance on choice as those fully or partly funded by the Local Authority. If such patients decline to accept advice, guidance and assistance, a risk assessment will be completed and arrangements will be made for their onward care on discharge from hospital. Once a patient is clinically fit for transfer to their usual place of residence of a less acute setting they will be subject to the Choice process.

1. INTERIM CARE
	* 1. Where people make an interim move into a care home, the Local Authority will ensure their name remains on a waiting list for the preferred choice care homes. Unless circumstances determine otherwise, the Local Authority should ensure that they should make only one such move before entering the care home of their choice.
		2. If a patient indicates he/she would prefer to stay in the interim care home, either when offered a place in one of the preferred care homes originally chosen or during the waiting process, the Local Authority would usually try to arrange this and amend any waiting lists accordingly
2. MENTAL CAPACITY
	* 1. It is recognised that most patients have the capacity to participate in making choices relating to planning their discharge from hospital.
		2. If the patient appears to be unable to make choices regarding discharge, despite efforts to help them communicate their wishes, the MDT will consult advocates, e.g. family or an Independent Mental Capacity Advocate (IMCA), in line with the Mental Capacity Act (2005), and make a Best Interest Decision as appropriate.
		3. Staff will be mindful of the obligation to seek the least restrictive option for the patient’s discharge and should follow Trust policies and procedures relating to Mental Capacity, Best Interest and Deprivation of Liberty Safeguards.

**9 DISCHARGE PLANNING**

9.1 There is a common approach across the NHS and Social Care in Oxfordshire, to achieve the timely and effective transfer of patients through the supported discharge pathway. This is contained in the Supported Discharge Pathway Operating Policy which brings benefits through shared behaviours, culture and practice to the organisations involved.

9.2 The discharge planning process should start before, or no later than 36 hours after admission for all patients.

9.3 The MDT will follow the Choice process and take a proactive approach to managing choice of care. The MDT will be conducted in accordance with the Standard Operating Process of the organisation involved.

9.4 The MDT will assess the patient on a daily basis. When the patient no longer requires hospital care and is clinically fit enough for discharge the patient will be declared fit for discharge and will be discharged to an appropriate location with appropriate care.

9.5 Whilst the patient still requires hospital care, the discharge plan options should be discussed with the patient and or their carer/ family to allow the patient to make an informed choice.

**10. ESCALATION PROCESS**

10.1 Responsibility for the discharge process will remain with a nurse at ward level. The nurse will undertake or delegate as appropriate the task of ensuring that MDT assessments are available to inform decisions about care needs upon discharge. The ward sister/ charge nurse will offer the appropriate level of guidance and support and will consult their Senior Nurse as needed. Concerns with discharge plans which will result in a delay in discharge, are to be escalated 30 minutes from decision following the organisations escalation process.

10.2 All staff are responsible for ensuring effective discharging planning is in place for every patient from the point of admission.

10.3 The MDT must ensure that discussion between the patient and their representatives has been undertaken prior to initiating the Choice process. Emphasis should be placed on accessing available support, clarification of the process and the possible need to transfer to an interim placement if the preferred option is not available.

**11. THE CHOICE PROCESS (Appendix 2)**

Stages 1 to 3 apply to every patient in order to provide support and prevent the need for further escalation:

* + - * + **Stage 1 – Provision of information to patient (Appendix 2);** TheEDD is to be given within 36 hours of admission. Once the patient pathway is agreed and the patient medically well the ‘Managing your discharge: patient information’ letter is issued (Appendix 2).
				+ **Stage 2 –** **Daily patient review**. If barriers are identified to effective discharge planning,[[1]](#footnote-1) a case conference will be arranged by the ward, led by the Senior nurse to include the patient and their representative within 5 working days. The Choice Process will be clearly explained and leaflets given to support verbal information within this case conference. The case conference will clarify the expectations of the patient, family or carer with regards to discharge planning and a further 5 working days will be afforded to engage in the process and prepare for discharge. This should be documented and a decision point added to the Board Round the following week to issue the TOC letter if resistance continues.
				+ **It is recognised that difficulties in securing an onward placement may rest with health and social care organisations, and not the patient or their family. If the delay in onward transfer of the patient is due to such reasons, this will be discussed with the patient and family, and confirmed via letter (as Appendices 3-5)**
				+ **Stage 3 –** **Preparing for discharge** to include; identification of onward care options, identification of two or more appropriate and available discharge destinations, provision of any outstanding documentation. The destination(s) may not always be the patient or representative’s preference.
			* Stages 4 and 5 represent the Formal Choice process:
				+ **Stage 4 –Formal letters;** A TOC letter is sent to the family, carer or patient within 48 hours of failure to comply with the agreed timescales as outlined within stage 2. A list of available onward care options are provided and a request to provide the ward with a decision of 2 options within 10 days. The letter will be prepared and signed by the divisional or clinical director There are three letters available depending on pathway:-

Appendix 6 Social Services Care Home

Appendix 7 Private Care Home

Appendix 8 Home with Private Package of Care

* + - * + **Stage 5 – Formal planned discharge process**; If after 10 days there has been no information regarding discharge provided by the patient/ family/carer, a second letter will be issued with either the name of an available care home or care provider that is able to meet the patient’s care needs and a confirmed date for discharge. The patient will be discharged in accordance with this letter. The letter will be signed by the director of clinical services/divisional director. There are two letters dependent on patient pathway:

Appendix 9 Private or Social Services Care Home

Appendix 10 Home with Private Package of Care

12. CONSULTATION & Approval Process

12.1 This document was developed following consultation with staffs of the Oxford Health Foundation Trust (OHFT), Oxford University Hospital (OUH) Trust and Oxfordshire County Council (OCC).

* 1. This guideline has been approved by; [TBC]

13. DISSEMINATION

* 1. The guideline will be placed on the OHFT and OUH Trust intranets and all users informed of its publication by email and at ward/unit meetings. New clinical staff will receive an overview of this policy during their induction.
1. EQUALITY IMPACT ASSESSMENT
	1. TBC – Appendix 1
2. REVIEW AND REVISION ARRANGEMENTS INCLUDING VERSION CONTROL

15.1 This guideline will be reviewed initially within 1 year and then every 3 years or sooner if required by organisational, structural or governance changes.

1. monitoring compliance and effectiveness
	1. Monitoring will be undertaken a minimum of yearly, facilitated by the Service Director Older Adult Directorate OHFT.
2. bibliography
	1. DH 2002. *National Service Framework for older people*. Department of Health
	2. DH 2003. *Community Care (delayed discharges etc.) Act*. HSC 2003/009 / LAC (2003)21 Department of Health
	3. DH 2004. *Continuing Care (National Health Services Responsibilities) Directions 2004.* Department of Health
	4. DH 2004. *Guidance on National Assistance Act (1948) (Choice of Accommodation) National Assistance (Residential Accommodation) (Additional Payments and Assessment of Resources) (Amendments) (England) Regulations 2001, “Choice Directive” (HSC 2001/015(LAC(2001)18), (LAC(2004)20)* Department of Health
	5. DH 2005. *Mental Capacity Act.* Department of Health
	6. DH 2009. *National Framework for NHS Continuing Healthcare and NHS-funded Care.* Department of Health

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| APPENDIX 1 – EQUALITY IMPACT ASSESSMENT |

To be completed by following the Trust Equality Impact Assessment Guidance

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| --- | --- |
| **Date of assessment** |  |
| **Division or Directorate:** |  |
| **Author:** |  |
| **Position:** |  |
| **Assessment area**  |  |
| **Purpose**  |  |
| **Objectives** |  |
| **Intended outcomes** |  |

**What is the overall impact on those affected?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Ethnic Groups | Gender groups | Religious Groups | Disabled Persons | Other |
|  |  |  |  |  |

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| --- |
| **Available information:**  |
| As per guidelines. |

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| --- |
| **Assessment of overall impact:**  |
| Low.  |

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| --- |
| **Consultation:** |
|  |

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| **Actions:** |
| None |

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| APPENDIX 2 – MANAGING YOUR DISCHARGE; PATIENT INFORMATION |

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| [INSERT ORGANISATION LETTER HEAD] |
| Dear………………………………………Your Ward Manager is …………………………………….Your Social Worker is (where applicable)………………………………………………… |  |
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**You Are Ready to Leave Hospital – What Happens Now?**

During your time in hospital your Care Team has made regular assessments of your abilities and needs.

We have assessed the help and support you need for now and you are fit to go to \*\*your home with care/a residential home/a nursing home/a community hospital\*\* [delete as appropriate].

Now you are at this stage, there are good reasons why you shouldn’t stay in hospital:

* A hospital ward is not the best place to continue your recovery once your acute illness is over
* Staying in hospital too long can make you lose confidence
* Staying in hospital may increase your risk of acquiring infection
* Other people are in need of an acute bed, we have a responsibility to make sure beds are vacated promptly to free them up for further use

**What happens next?**

Your team will work with you and/or your family to find an appropriate \*\*care package/residential home/nursing home/**community hospital**\*\* [delete as appropriate] that *has a vacancy*.

We will make every effort to meet your preferences on your next steps. If you find a \*\* residential or nursing home \*\* [delete as appropriate] that does not have a vacancy, you will be asked to move to a suitable alternative until your first choice vacancy becomes available. **If you need a Community Hospital, we will transfer you to the first available bed anywhere in Oxfordshire in order to maximise your therapy and rehabilitation opportunities. If this is not in your local Community Hospital, it is possible for you to move to the next available bed there.**

**Timescales**

When you no longer need an acute/community hospital bed but need ongoing care and have been offered a vacancy it is expected that you will leave hospital within two weeks.

Support will be available throughout the discharge process and you should speak to me if you have any questions or concerns. Most people are able to move once the team have agreed they are fit but there can be disagreements about the timing or the care required, we will work with you to resolve these.

We are all here to help and recognise that discharge from hospital can be a difficult and stressful time for patients, families and carers.

Yours sincerely,

[**INSERT SIGNATURE BLOCK OF AUTHORISED SIGNATORY]**

**Overview of the discharge process**

**Stage 1: Provision of information**

* You should be given yourEstimated Date of Discharge within 36 hours of admission.
* A multi-disciplinary team meeting on the ward agrees the date at which you no longer need an acute/community hospital bed.
* We will then discuss with you and offer an appropriate care programme to meet your assessed continuing needs as quickly as possible.

**Stage 5:** **Formal** **planned discharge**

* If after 10 days you have not provided us with any information regarding discharge, we will give you another letter providing the name of an available care home or provider that is able to meet your needs with a confirmed date for discharge.
* We will plan to discharge you as described in this letter.

**Stage 4:** **Formal Letters**

* If you cannot arrange an alternative within the timescales identified in Stage 2, you will be given a Transfer of Care letter with a list of vacancies
* You will be asked to choose 2 options from this list and inform us of your decision within 10 days so we can arrange your discharge

**Stage 3:** **Prepare for discharge**

* An alternative care programme is agreed with you (this may not be your preferred choice)
* Your discharge is arranged

*Where an agreement cannot be reached, the formal stage 4 and 5 process will commence.*

**Stage 2:** **Daily review**

* If your appropriate care programme is unavailable due to a lack of vacancies in health or social care organisations, we will discuss this with you and give you a letter explaining this.
* If you refuse the offered care programme, [named nurse or social worker] will arrange to meet with you within 5 working days to explore your reasons.
* At this meeting you will be given another 5 working days to arrange an alternative.

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| APPENDIX 3 – DTOC – oxfordshire reablement service (ORS) |

**[INSERT ORGANSIATION LETTER HEAD]**

Dear [patient name]

You have been a patient on **[Name]** Hospital since [**date]** following **[diagnosis**]and we are pleased that you arenow ready to leave. We have completed all the assessments and agreed that yourcare needs can be best met with care at home.

We have not forgotten about you but unfortunately the Oxfordshire Reablement Service has not yet been able to provide the package of care at home that can meet your needs. We are continuing to check for availability every day and will tell you as soon as the care is available.

We appreciate that this has been a difficult time for you and we recognise your needs are no longer being met by remaining in a hospital bed. It is agreed that it is in yourbest interests to return home where you can be in a more settled environment.

We are happy to discuss any concerns you have.

Yours Sincerely

[**INSERT SIGNATURE BLOCK OF AUTHORISED SIGNATORY]**

|  |
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| APPENDIX 4 – DTOC – Package of care at home |

**[INSERT ORGANSIATION LETTER HEAD]**

Dear [patient name]

You have been a patient on **[Name]** Hospital since [**date]** following **[diagnosis**]and we are pleased that you arenow ready to leave. We have completed all the assessments and agreed that yourcare needs can be best met with care at home.

We have not forgotten about you but unfortunately we have not yet been able to find a care agency able to provide the package of care at home that can meet your needs. We are continuing to check for availability every day and will tell you as soon as the care is available.

We appreciate that this has been a difficult time for you and we recognise your needs are no longer being met by remaining in a hospital bed. It is agreed that it is in yourbest interests to return home where you can be in a more settled environment.

We are happy to discuss any concerns you have.

Yours Sincerely

[**INSERT SIGNATURE BLOCK OF AUTHORISED SIGNATORY]**

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| APPENDIX 5 – DTOC – care home |

**[INSERT ORGANSIATION LETTER HEAD]**

Dear [patient name]

You have been a patient on **[Name]** Hospital since [**date]** following **[diagnosis**]and we are pleased that you arenow ready to leave. We have completed all the assessments and agreed that yourcare needs can be best met in a residential/nursing home.

We have not forgotten about you but unfortunately we have not yet been able to find a residential/nursing home with a vacancy that can meet your needs. We are continuing to check for availability every day and will tell you as soon as there is a residential/nursing home bed available.

We appreciate that this has been a difficult time for you and we recognise your needs are no longer being met by remaining in a hospital bed. It is agreed that it is in yourbest interests to move to a residential/nursing home where you can be in a more settled environment.

We are happy to discuss any concerns you have.

Yours Sincerely

[**INSERT SIGNATURE BLOCK OF AUTHORISED SIGNATORY]**

|  |
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| APPENDIX 6 – FIRST TOC LETTER - Social Services funded care home |

**[INSERT ORGANSIATION LETTER HEAD]**

Dear [**patient name]**

You have been a patient on **[Name]** Hospital since [**date]** following **[diagnosis**]and we are pleased that you arenow ready to leave. We have completed all the assessments and agreed that yourcare needs can be best met in a residential/nursing home..

On **[date]** you were awarded Social services funding. Following a discussion with **[name of team member]** we asked you to identify a suitable care home and gave you information regarding the homes in Oxfordshire which will accept the Social Services funding. Unfortunately you haven’t told us your decision so we are sending you a list of homes with current vacancies. Please be aware that these vacancies may change due to demand for beds. We ask you to identify at least 2 homes from this list by [**date 10 days later]** so that the home can make an assessment and you can move.

We appreciate that this has been a difficult time for you and we recognise your needs are no longer being met by remaining in a hospital bed. It is agreed that it is in yourbest interests to move to a residential/nursing home where you can be in a more settled environment.

We are happy to discuss any concerns you have but please be aware if you decline to identify a placement during the time frame stated above, we will have to take further action. Please address any questions or concerns you may have with [**Senior Nurse contact details]** in the first instance.

Yours Sincerely

[**INSERT SIGNATURE BLOCK OF AUTHORISED SIGNATORY]**

APPENDIX 7 – first toc letter - Privately funded care home

**[INSERT ORGANSIATION LETTER HEAD]**

Dear [**patient name]**

You have been a patient on **[Name]** Hospital since [**date]** following **[diagnosis**]and we are pleased that you arenow ready to leave. We have completed all the assessments and agreed that yourcare needs can be best met in a residential/nursing home.

Following a financial assessment by the social services team I understand that youwill initially be funding care privately and that your social worker has provided you with information regarding the homes with vacancies in Oxfordshire. Unfortunately you haven’t told us your decision so we are sending you a list of homes with current vacancies. Please be aware that these vacancies may change due to demand for beds. We ask you to identify at least 2 homes from this list by [**date 10 days later]** so that the home can make an assessment and you can move.

We appreciate that this has been a difficult time for you and we recognise your needs are no longer being met by remaining in a hospital bed. It is agreed that it is in yourbest interests to move to a residential/nursing home where you can be in a more settled environment.

We are happy to discuss any concerns you have but please be aware if you decline to identify a placement during the time frame stated above, we will have to take further action. Please address any questions or concerns you may have with [**Senior Nurse contact details]** in the first instance.

Yours Sincerely

[**INSERT SIGNATURE BLOCK OF AUTHORISED SIGNATORY]**

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| --- |
| APPENDIX 8 – first TOC letter – Package of Private Care at home |

**[INSERT ORGANSIATION LETTER HEAD]**

Dear [patient name]

You have been a patient on **[Name]** Hospital since [**date]** following **[diagnosis**]and we are pleased that you arenow ready to leave. We have completed all the assessments and agreed that yourcare needs can be best met with care at home.

Following a discussion with **[name of team member]** we asked you to identify a suitable private package of care and gave you information regarding the care providers in Oxfordshire. Unfortunately you haven’t told us your decision so we are sending you a list of care providers with current capacity to pick up care. Please be aware that the status of the vacancies on the list may change due to demand for packages of care. We ask you to identify a provider from this list by [**date 10 days later]** so that an agency can make an assessment and you can move.

We appreciate that this has been a difficult time for you and we recognise your needs are no longer being met by remaining in a hospital bed. It is agreed that it is in yourbest interests to return home where you can be in a more settled environment.

We are happy to discuss any concerns you have but please be aware if you decline to identify a care provider during the time frame stated above, we will have to take further action. Please address any questions or concerns you may have with [**Senior Nurse contact details]** in the first instance.

Yours Sincerely

[**INSERT SIGNATURE BLOCK OF AUTHORISED SIGNATORY]**

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| APPENDIX 9 – second toc letter – PRIVATE or social services funded care home |

**[INSERT ORGANSIATION LETTER HEAD]**

Dear [**patient name]**

You have been a patient on **[Name]** Hospital since [**date]** following **[diagnosis**]and we are pleased that you arenow ready to leave. We have completed all the assessments and agreed that yourcare needs can be best met in a residential/nursing home.

We appreciate that this has been a difficult time for you. However, you are fit to leave and by remaining place yourself at risk of developing hospital-borne infections. Moreover, we have an urgent need to move patients through the health system and make beds available for the medically unwell.

It was agreed on **[date]** that it is in your best interests to be discharged to a residential/nursing home where you can be in a more settled environment

Following a discussion with [**name of team member**] you were asked to identify a suitable care home and were given information regarding the homes in Oxfordshire. On **[date of previous letter]** we sent you a letter with the list of current vacancies asking you to identify at least 2 vacancies by **[date given].**

As you have not informed us of your choice of homes, we plan to move you to [**name of home] [location of home**] on [**date within 7 days**]. You will be able to continue with negotiations to move on to the home of your choice from this placement if you should wish to.

If you wish to discuss this further please contact **[Senior Nurse contact details]** in the first instance.

Yours Sincerely

[**INSERT SIGNATURE BLOCK OF AUTHORISED SIGNATORY]**

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| APPENDIX 10 – second TOC letter - Package of Private Care at home |

**[INSERT ORGANSIATION LETTER HEAD]**

Dear [**patient name]**

You have been a patient on **[Name]** Hospital since [**date]** following **[diagnosis**]and we are pleased that you arenow ready to leave. We have completed all the assessments and agreed that yourcare needs can be best met in a residential/nursing home.

We appreciate that this has been a difficult time for you. However, you are fit to leave and by remaining place yourself at risk of developing hospital-borne infections. Moreover, we have an urgent need to move patients through the health system and make beds available for the medically unwell.

It is agreed that it is in yourbest interests to return home where you can be in a more settled environment.

Following a discussion with [**name of team member**] you were asked to identify a suitable care agency and were given information regarding the care agencies in Oxfordshire. On **[date of previous letter]** we sent you a letter with the list of agencies with current vacancies asking you to identify a suitable agency by **[date given].**

As you have not informed us of your choice of agency, we plan to discharge you home with [**name of agency]** on [**date within 7 days**]. You will be able to continue with negotiations to choose an agency of your choice from home if you should wish to.

If you wish to discuss this further please contact **[Senior Nurse contact details]** in the first instance.

Yours Sincerely

[**INSERT SIGNATURE BLOCK OF AUTHORISED SIGNATORY]**

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| APPENDIX 11 – continuing healthcare letter |

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**For information**

|  |  |
| --- | --- |
| The discharge pathway for people eligible for a full Continuing Healthcare assessment. | **Continuing Care****Abingdon Community Hospital****Marcham Road****Abingdon, Oxon****OX14 1AG****Tel: 01235 205784****Fax: 01235205781** continuing.care@oxfordhealth.nhs.uk |

 [**DATE]**

**[Re:] [DOB:]**

As part of your discharge plan that [**name/you**] {**requires/require**] a Checklist referral for consideration for NHS Continuing Healthcare funding. This process is to determine whether someone is eligible for NHS continuing healthcare or NHS-funded nursing care.

If the Checklist referral demonstrates that [**name/you**] [**is/are**] eligible for a full continuing care assessment, the NHS remains responsible for funding the care provision during the assessment process.

In Oxfordshire Interim Funding arrangements are put in place, this means that [**name/your**] care provision will be funded until a decision is made on eligibility for continued NHS funding. Oxfordshire has a contract with the Orders of St John Care Trust and a placement will be found in one of their homes within Oxfordshire. Packages of care at home can be arranged where it is agreed that it is in the best interest of an individual to return to their own home.

This process is expected to take up to eight weeks and allows sufficient time for [**name/you**] to settle into the home and for the care staff to understand [**your/his/her**] care needs prior to the assessment being completed.

If the full assessment shows that [**name/you**] [**has/have**] needs eligible for Continuing Care funding the NHS will continue to pay for [**name/your**] healthcare provision and will support any appropriate and necessary transfers to alternative placements.

If the outcome of the full assessment is that [**name/you**] [**does/do**] not have needs eligible for Continuing Care funding [**name/you**] will be required to make alternative arrangements for the care provision from the date of the decision for eligibility.

If the decision is that you do not have needs eligible for NHS Continuing Healthcare funding, in addition to the national Funded Nursing Care contribution, [**name/you**] may be eligible for some support from social services. If [**name/you**] [**is/are**] assessed as being eligible under their criteria, [**name/you**] would be expected to complete a financial assessment to determine whether they would financially support any part of [**name/your**] care costs. The financial services team is alerted to the discharge date and will send the forms to you directly.

Yours Sincerely

Oxfordshire Continuing Care Service

1. Barriers to discharge : see discharge pathway sops [↑](#footnote-ref-1)