1 Introduction

‘At least 80% of patients discharged from hospital can be classified as simple discharges: they are discharged to their own home, and have simple on-going health care needs which can be met without complex planning. Changing the way in which discharge occurs for this large group of patients will have a major impact on patient flow and effective use of bed capacity.’

(Achieving timely ‘simple’ discharge from hospital, DoH 2004)

2 Patient information

Anybody coming into hospital will be given information about their stay in hospital and the expected date and time of their discharge (see Appendix 1: Planning Your Discharge). Patients/carers will give staff information about their social circumstances, which might include the single assessment summary.

3 Discharge planning

Key points for achieving timely discharge include:

- all patients should have a treatment plan within 24 hours of arrival
- an expected date of discharge should be set within 24 hours of arrival by the multi-disciplinary team, and the patient and family/carer informed. Elective patients will be informed of their predicted length of stay at pre-assessment
- the expected date of discharge will be pro-actively managed against the treatment plan on a daily basis and formally reviewed at each multi-disciplinary meeting and changes communicated to the patient
- ward rounds will be scheduled to allow a senior review of all patients at least daily
- nurse- or therapy-led discharge according to agreed policy
- inpatient discharges should be planned to occur before 12 noon, and on any day of the week, including weekends.

4 Involvement of other professionals

The multi-disciplinary team is responsible for timely and appropriate referrals to other professionals, taking into account the expected date of discharge, and recognising relevant legislation (Appendix 2: Discharge Algorithm). The multi-disciplinary team will:

- plan and instigate diagnostic tests and other interventions to avoid delays in treatment
- daily review the patient’s response to treatment and their condition

5 Discharge documentation

The green discharge form is the principal tool for recording and co-ordinating information relating to a patient’s discharge. Individual members of the multi-disciplinary team will take responsibility for their part of the discharge plan, communicating with the multi-disciplinary team, and recording information on the discharge form. They will communicate effectively with the patient and the family.

Traffic light software has been installed on all inpatient wards to manage length of stay and patient discharge. It is designed to highlight patients who are due to be discharged within 48 hours. An up-dated list of expected discharges will be used at shift handover.
Complex discharges are to be identified at an early stage and highlighted on the traffic light system, making reference to continuing care at an early stage.

6 **Community hospital waiting list**

Patients who are likely to transfer to a community hospital will be entered on the pending list on the community hospital waiting database. Community hospital staff will be responsible for assessing the suitability of the patient for transfer. When the patient is within 5 days of being medically fit for discharge, they will be transferred to the active waiting list (see Appendix 3: West of Somerset Community Hospital Waiting List flowchart).

7 **Arrangements for discharge**

On the agreed day of discharge the Nurse in charge of the ward is responsible for executing the discharge. This may require appropriate use of the Discharge Lounge at Musgrove Park.

Refer to the Discharge Checklist/Plan to ensure completion of the various components of discharge (eg TTA’s, transport, etc) (see Appendix 4: West of Somerset Discharge Checklist/Plan).

Discharge summaries are to be handed to patients at the time of discharge, for the patient’s GP, with other copies being distributed as stated locally.

8 **Patients requiring placement**

All patients requiring a placement will receive a letter outlining the hospital’s expectations regarding discharge (regardless of funding arrangements). (See Appendix 5: Complex Discharge Policy).

9 **‘Reluctant’ discharges**

The multi-disciplinary team will identify potential ‘reluctant’ discharges and discuss these with Sister and Matron. Continuing Healthcare should be considered (see Appendix 5: Complex Discharge Policy).

10 **Audit and evaluation**

The following measures will be used to continually review the impact of the Discharge Policy:

- Patient readmission rates
- Documentation audit
- Discharge rate by day of week and time of day
- Patient satisfaction survey

**Issued:** November 2005

**Authorised:** . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

**Liz Redfern, Director of Patient Care and Nursing**

**Review Date:** November 2007

**Expiry Date:** November 2008

TAUNTON & SOMERSET NHS TRUST
WEST OF SOMERSET DISCHARGE POLICY
AUTHOR: HELEN MUIR, PROJECT LEAD – EMERGENCY CARE REFORM
TP5.05/NOVEMBER 2005
If there is a delay in arranging any alternative provision there are short stay beds available at:
- The Willows, Bridgwater
- Popham, Wellington

Information about this is available from your Social Worker.

**The day of your discharge**

A final check will take place to ensure that everything is in place for your discharge.

On the day of your discharge, if you do not need to stay in a bed for medical reasons, you will need to be ready to leave the ward **by 11am at the latest**. If necessary the ward staff can arrange for you to wait in the comfort of the Discharge Lounge for your relatives or for any drugs you need to take home with you.

A supply of your current medication may be given to you or your carer. If you have any questions or concerns about your medication, please speak to the nurse in charge, or contact Medicines Information on 01823 342253. This service is available from Monday to Friday, 9am to 5pm.

Advocacy support is available for patients and carers from:

**Age Concern**
01823 26212

**Care Direct**
0800 444000

**Useful Contacts**

Ward .................................................

Social Worker: ...........................................

Occupational Therapist:
.........................................................

Physiotherapist:
.........................................................

Community Nurse:
.........................................................

---

**Planning Your Discharge**

Patient: .........................................................

Admission Date: .........................................................

Planned Discharge Date: .........................................................

**Patient Information**

GH018
July 2003
Helen Muir
Our commitment to you

Welcome to Taunton and Somerset Hospital.

We appreciate that a hospital stay can be a stressful and worrying time. We will offer support and advice to you and your family or carers throughout your hospital stay. We will discuss with you the continuing support you may need when you return home, to make the transition as easy as possible for you.

If you have any queries regarding the information in this leaflet, please don’t hesitate to ask any member of the team that is caring for you. They will be happy to help you.

Thank you for your co-operation. This helps us to offer an efficient and effective service to all those people who require treatment in our community hospitals.

Planning for your discharge or transfer from hospital

This hospital is the right place to be when you are in need of specific acute care. However, when your treatment is complete, it is important that you can leave hospital as soon as possible so that another patient can be admitted to receive treatment.

We will start planning for your discharge as soon as you are admitted. This means that we can begin to:

- Assess what your needs are likely to be when you are ready to go home
- Involve any relevant staff who can help in meeting those needs, such as an Occupational Therapist, Physiotherapist, GP, Speech Therapist, Community Nurse, Social Worker, etc.
- Make arrangements for equipment or services that you may need when you leave hospital

Working together

All staff will work with you and your relatives to plan an effective discharge or transfer.

You or your family may have concerns, such as your future safety at home, your ability to move around, or managing your personal care and domestic arrangements. If so, please don’t hesitate to raise these with a member of staff at the earliest opportunity.

When we know what date your hospital treatment will be complete, you will be given an expected discharge or transfer date. It is important that you are aware of this so that necessary arrangements can be made. These arrangements may include:

- Transport home - patients are normally expected to arrange their own transport
- Suitable clothing and footwear (if you are not already using them in hospital)
- Access to a key to your property
- Adequate basic food supplies
- Adequate heating in your home
- Delivery of any equipment needed to provide continuing care in your home

Further support

If there are difficulties in returning to your home, a number of options can be considered. A Social Worker is available to discuss these with you and your family. These can include:

- Transfer to a community hospital
- An emergency call system at home
- Adaptations in your own home
- Moving to sheltered housing
- Moving to extra care housing where there is 24 hour support and care
- Short stays in a Residential and Nursing Home
- Longer term accommodation in a Residential or Nursing Home
West of Somerset - Discharge Algorithm

Pre-Operative Assessment Clinic

- Estimated date of discharge
- Home care arrangements
- ‘Planning your discharge’ leaflet
- Discharge checklist form started

Admission:

- Emergency
- Elective
- Day case
- Transfer in from other hospital or specialist area

Estimated date of discharge confirmed within 24hrs of admission

Adult patient considered for future transfer to community hospital, and referred on community hospital software

Patient/Parent given a ‘Planning your Discharge’ leaflet (if not already done)

Check if SAP completed if patient is from NH, RH or own home with complex needs

Start discharge checklist form

Estimated Date of Discharge on patient’s bed head, IHS, and Traffic Light software

EDD within next 5 days: refer to community hospital waiting list

Patient and family made fully aware of expected date and likely time of discharge to enable them to plan transport and home arrangements

Medical staff confirms patient’s suitability for nurse-led discharge and prescribes pre-emptive discharge drugs

Simple discharge

Discharge checklist form completed

Patient’s drugs available

Transport arranged (letter for WAST if pt NFR)

Equipment available for discharge

Patient discharged by 11am

Discharge Lounge / Home

Discharge letter to: GP, DN/CCN, HV/School Nurse, Practice Nurse, cc: Patient’s Medical Record

Self discharge

Doctor reviews patient

Patient/Parent signs self discharge form

Promote safety by alerting family and community services (consider patient confidentiality and consent issues)

Complex discharge (Adult)

MDT request for assessment:
- Single assessment process (Section 2 for social work asst – respond within 48 hrs)
- Assessment within 3 working days of request for DN

DN assessment:
- Fax or phone surgery
- Report sent to SW or Community social worker (no timescale)
- Consider eligibility for Continuing Health Care

CPN assessment if required

Referral to Learning Disabilities Team if required

SW assessment, discusses options with patient and family

Delayed discharges: Refer to West of Somerset Reluctant Discharge protocol

Nursing and/or equipment needs identified and provided

Section 5 notification of EDD to Social Worker if not self-funded
Appendix 3

ELECTRONIC COMMUNITY HOSPITAL WAITING LIST

STAGE 1  PATIENT IDENTIFIED FOR POSSIBLE TRANSFER ON ADMISSION

MPH: Patient admitted to ward

MPH: Patient identified as possibly needing transfer to community hospital

MPH: Community hospital waiting list:
- Patient details
- Circumstances
- Expected date of transfer
Draft/not referred list

MPH: Patient details
Referred to pending list

Patient discharged

24 hrs

Community hospital:
- Review referred list
- Accept patient, in principle, to Pending list

Referral rejected

STAGE 2:  PATIENT FIT FOR DISCHARGE WITHIN NEXT 5 DAYS

MPH: Ward complete clinical details
(Req 1-4, Completion 1)
with predicted transfer date
Referred to waiting list

Patient discharged

24 hrs

Community hospital:
- Review patients referred to waiting list
- Give predicted transfer date (ie bed available)
- Accept to active waiting list

Referral rejected

Community hospital:
- Confirm/agree transfer date with MPH (Completion 2)

Patient removed from system
<table>
<thead>
<tr>
<th>Addressograph label</th>
<th>Hospital:</th>
<th>Estimated discharge</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ward:</td>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Time:</td>
<td></td>
</tr>
</tbody>
</table>

| Discharge destination: | | |
|------------------------| | |
| **Agreed** by patient/Carer and next of kin | | |

| Name of clinician authorising discharge | |
|----------------------------------------| |

<table>
<thead>
<tr>
<th>Patient aware of diagnosis?</th>
<th>□ Yes □ No N/A</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Prescription ordered</th>
<th>Date:</th>
<th>Received on ward</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Medication instructions discussed and understood</th>
<th>□ Yes □ No</th>
</tr>
</thead>
</table>

| Further requirements eg dosette boxes (funding identified?) | |
|-------------------------------------------------------------| |

| Dressings, catheter/stoma bags, etc provided (3 days supply) | |
|----------------------------------------------------------------| |

| District Nurse/CCN referral made | Date: | Referrer: | |
|----------------------------------|-------|-----------| |
| Letter written to District Nurse | Date: | Sent: to surgery with patient | |
| Letter written to HV/School Nurse| Date: | Sent: to surgery with patient | |
| Social Worker referral made      | Date: | |

| Domestic arrangements: | |
|-----------------------| |

| Valuables returned | |
|--------------------| |

<table>
<thead>
<tr>
<th>House keys</th>
<th>□ Yes □ No</th>
<th>Food</th>
<th>□ Yes □ No</th>
</tr>
</thead>
</table>

| Transport: | Own transport | |
|------------|----------------| |
| Hospital transport booked | □ Yes □ No | Booking no: |
| (remember access to home: Steps / stairs (internal / external)) | |

<table>
<thead>
<tr>
<th>Outpatient appointment required</th>
<th>□ Yes □ No</th>
<th>Details</th>
</tr>
</thead>
</table>

| Medical equipment/devices removed from patient | |
|------------------------------------------------| |

<table>
<thead>
<tr>
<th>Date of discharge</th>
<th>Signature of Discharging Nurse</th>
<th>Printed name</th>
</tr>
</thead>
</table>

If this patient is a more complex discharge, continue overleaf for detailed discharge planning.
Complex Discharge – Planning

Patient at risk because (tick relevant boxes)

- [ ] Already receives community services
- [ ] Has mobility problems
- [ ] Has cognition problems
- [ ] Family / carers or staff have concerns

Details ........................................................................................................................................................................
........................................................................................................................................................................

Single assessment summary already available? [ ] Yes [ ] No

<table>
<thead>
<tr>
<th>Referral to / request for assessment:</th>
<th>Telephone or written referral?</th>
<th>Date requested</th>
<th>Worker's name</th>
<th>Referrer's initials</th>
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</thead>
<tbody>
<tr>
<td>OT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physio</td>
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<tr>
<td>SW</td>
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<tr>
<td>CPN</td>
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</tr>
<tr>
<td>GP</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>DN/CCN</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Community Matron/Case Manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care home matron</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Red Cross Home from Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HV/School Nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inform Police</td>
<td></td>
<td></td>
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</tbody>
</table>

Difficult/Reluctant Discharges (refer to Policy)

<table>
<thead>
<tr>
<th>Action</th>
<th>By whom</th>
<th>Date of issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Letter 1 issued</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Letter 2 issued</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Letter 3 issued</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Discharge arrangements in place (signature)
GOOD PRACTICE IN HANDLING DIFFICULT OR RELUCTANT DISCHARGES FROM HOSPITAL CARE
CONTENTS

1 Context .......... Page 3
2 Government guidance ....... 3
3 General principles ........ 3
4 Implementing complex discharge .... 4
5 Checklist at the point of discharge .... 5

APPENDICES

I Flow chart (implementing discharge) ..... 6
II Letter 1 – to all patients with complex discharge needs ..... 7
III Letter 2 – to potential difficult or reluctant discharges ..... 8
IV Letter 3 – final letter to reluctant discharges ...... 9
1. **CONTEXT**

1.1 The vast majority of discharges in Somerset are implemented in the context of care plans agreed by all parties, including patients, their families and/or their carers. Good communications should be apparent from the point of admission with patients being clear about their rights, the care they should expect to receive and what, in return the NHS might expect from the patient.

1.2 However, there are inevitably a small number of situations where this is not possible. This is most likely where patients do not meet the NHS criteria for continuing care, but patients and/or families or other carers refuse the recommended option of a nursing home or residential home placement for adults, or home care for children.

1.3 In the event of this situation occurring it is not possible for patients to stay in a hospital bed whilst they await their preferred choice and it will be necessary to find alternative accommodation:

   i.e.  for adults:  
   Short term residential/nursing home beds (interim)  
   Short-term beds in either extra housing or residential rehab  
   Second choice of nursing/residential care  

   for children:  
   Foster care  
   Short-term residential care  
   Adult nursing home  

1.4 There may also be instances where patients refuse to transfer to a community hospital, or where discharge is delayed pending the availability or support of the family/carer.

1.5 Further consideration needs to be given to situations where:

   - Patients, or parents of children, who have no fixed abode and require medical cover, but a GP requires an address before cover can be provided
   - Agencies do not take responsibility for providing a suitable placement for someone with mental health, behavioural problems and learning difficulties.

2. **GOVERNMENT GUIDANCE**

2.1 The original Guidance on Continuing Care HSG (955) 8 outlines the context regarding rights on Hospital discharge. Section 27-29 states:

   “Where patients have been assessed as not requiring continuing inpatient care, as now, they do not have the right to indefinitely occupy an NHS bed. In all but a very small number of cases, where a patient is being placed under Part II of the Mental Health Act 1983, they do however have the right to refuse to be discharged from NHS care in to a nursing home or residential care home.

   In such cases the Local Authority should work with Hospital and community based staff and with the patient, his or her family and any carer to explore alternative options.”

3. **GENERAL PRINCIPLES**

3.1 Staff should refer to the West of Somerset Discharge Policy.
3.2 Throughout the processes of admission, assessment and care planning, close contact must be maintained with the patient, carers or interested relatives. They should be kept informed with relevant information, answering questions that arise and alerting them in good time to choices and decisions that will have to be made.

3.3 Where decisions about future care have been made, these should be clearly relayed with full, written explanations, including likely funding implications.

3.4 In cases of dissatisfaction with proposed discharge arrangements, patients must be informed of their rights including the right to a second medical opinion from within the same Trust, access to the Continuing Care Review Panel, the general complaints procedures and the Patient Advice and Liaison Service (PALS), and independent advocacy services (eg Age Concern).

3.5 There is a need to act promptly if the Review Panel upholds the discharge decision and discharges should not be suspended if the complaints route is subsequently pursued.

3.6 Legal advice should be sought at an early stage if there are doubts or uncertainties about anticipated actions and patients/relatives/carers should be advised that they might also wish to seek legal advice.

3.7 It is important to ensure that communication takes place with the appropriate person in cases where the patient is not able satisfactorily to act on their own behalf. This may be an attorney appointment under a Power of Attorney (whether a general power or an enduring power) or in the case where there is no Attorney, ensuring that the appropriate individuals are involved (although the law is unclear regarding nominated individuals).

4. IMPLEMENTING DISCHARGE – See Flow Chart (Appendix I)

4.1 All adult patients requiring placement in a nursing or residential home will be given a discharge letter (Appendix II) by Nursing staff asking the patient or carers to find a Home.

4.2 In most cases there will be clear signals if patients or carers are likely to be reluctant for the discharge to go ahead. As such signals emerge, it may be clinically appropriate in some circumstances to move the patient to a different setting so that all parties can take stock of the situation.

This may be viewed merely as a postponement of the decision, but it emphasises that a patient does not have a right to occupy a particular bed or to stay in a particular setting (although transfer does not affect the patient’s status).

4.3 Where patients or carers appear to be reluctant to discharge, the Ward Sister will give the patient and/or carer a letter (Appendix III) outlining the need to transfer to alternative accommodation with the support of the health and social care team.

4.4 If a clinical decision is reached, in conjunction with the multi-disciplinary team that discharge is appropriate, it is important, where the patient and/or family are reluctant, that managerial support for nursing staff and other clinicians is available.

4.5 The appropriate matron should be made aware of the emergency situation and reference should be made to the Deputy Director of Nursing and the Health and Social Care Team Managers to check that all procedures have been proactively applied.
5. **CHECKLIST AT THE POINT OF DISCHARGE**

As the implementation of the discharge is reached, the following checklist should be followed:

5.1 Check that the position remains unchanged, and the discharge option remains viable and still has the backing of the GP, and any other key members of the multidisciplinary team.

5.2 Be satisfied that the patient and/or family understand the consequences of what is happening and the practical steps involved in the discharge process.

5.3 Letter (Appendix IV) given by the Associate Director of Nursing to the patient and/or relatives and/or carers summarising previous written communications, restating the Care Plan and starting the intention to discharge within 7 days.

5.4 Check with all relevant Health and Social Services staff that the necessary arrangements are in place for the discharge plan to be actioned.

5.5 If a patient or parent refuses discharge on the day; seek further legal advice to confirm the legality of the discharge plan/procedure.

5.6 Discharge the patient if legal advice indicates that it is lawful to do so.

5.7 In the event of an adult patient refusing to leave the hospital premises to an appropriate and safe location the ward would formally discharge the patient as the duty of care will have ceased and continued occupation would result in an action of trespass by the former patient.

5.8 In the event of parents/carers refusing to take their child out of hospital to an appropriate and safe location, the ward staff would make a formal referral to Social Services for emergency foster care.

**Caveat.** Assistance may be sought from the appropriate agency i.e. Police, Local Authority, Housing Association.
Multidisciplinary assessment process completed

Patient deemed appropriate to be transferred to nursing home/residential home placement/or other setting e.g. home

**Letter 1** given by Nursing staff to all patients transferring to nursing home or residential home, and documented on Discharge Checklist

Transfer discussed with patient/carer, ward sister & member of the Health & Social Care Team / Community Social Worker. A care plan letter to be given to relevant patients from Social Care Team

Patient agrees with transfer

Transfer arranged and completed

Patient/carer disagrees

Patient/carer seen by Ward Sister & Health & Social Care Team / Social Worker to continue to explore options. **Letter 2** given to patient by Sister and documented on Discharge Checklist. Patient must be recorded as category 18 on SITREP

Patient/carer seen by Matron Health & Social Care Team Manager. **Letter 3** given to patient by Assoc. Director of Nursing, 7 days after **Letter 2** and documented on Discharge Checklist

Continuing disputes referred to Director of Nursing and then Chief Executive
Letter 1: given, by Nursing Staff, to all adult patients and/or carers preparing for discharge to a nursing or residential home

Date:

Name and address

Dear

Following discussion with you, your family/carer it has been decided that your care needs can no longer be met in your usual home environment. It has now become necessary for you and your family to identify a residential/nursing home for you to be discharged to.

The nursing, social care and hospital staff are available to help you with the decision and support your discharge. If you have any questions, please do not hesitate to talk to them.

We would ask you and your family to make several choices of Homes. If your first choice is not immediately available, we will need you to take up an alternative with the option to transfer to your first choice as soon as possible.

Yours sincerely

Sister

Team Manager, (Social Services)
Letter 2: given, by Sister, to adult patients and/or carers who may be reluctant to discharge

Date

Patient’s Name and Address

Dear

As you will know from discussions with the team looking after you since you came into hospital, and staff involved in your care, you are now fit for discharge. After consultation with you and the Health and Social Care Team or Social Worker, it is now necessary to ask you to transfer to alternative accommodation for the next stage in your care.

We are sorry that we have to ask you to do this, but it is important that you are able to leave hospital as soon as you are fit so that you do not risk further medical complications caused by a prolonged hospital stay. It also enables the hospital to provide treatment for further patients that need hospital care.

We appreciate that this may be a difficult time for you, and your family, as the home of your choice/care package may not be available for you immediately. We can therefore arrange for you to be placed in alternative accommodation whilst you wait for a vacancy/care package to become available.

You and your family will be supported throughout this time to ensure that the transfer is made as smoothly as possible. Please be assured that placement in alternative accommodation will hopefully be short-term and that when a vacancy does arise, arrangements will be made for you to transfer with the transportation costs incurred by us.

Throughout this period, the ward sister and a member of the Health and Social Care Team will be available to help you and answer any of your questions.

Yours sincerely

Matron

Area Manager – Adult Social Care
Letter 3: given, by Associate Director of Nursing, to adult patient and/or carer 7 days after Letter 2 (i.e. nearest working day)

Date

Patient’s Name and Address

Dear

YOUR DISCHARGE FROM HOSPITAL

As we said in our last letter, we are pleased that you are now well enough to leave hospital.

We understand that up to now, you have been unable to secure a place in the home of your choice. It may be that your home choice does not have a vacancy at this time. We do not wish to cause you or your family undue anxiety or distress, but you will be aware that there are many people needing hospital care and we need to be able to offer treatment to others requiring care at the earliest opportunity.

We would like to complete your move out of hospital as smoothly as possible. We are therefore providing you with a listing of homes (enclosed with this letter) with vacancies that would be able to support you whilst you identify or finalise your home of choice – or until a place becomes vacant in the home you have chosen. One of these homes will be able to provide you with the level of care and support that you currently require. The Trust will, therefore, formally discharge you to your choice of one of these homes within the next week.

All members of the multi-disciplinary team will assist you with the transfer and answer any questions about your care. Alternatively, if you, or someone representing you, would like to discuss this decision with a Senior Trust Manager, please do not hesitate to contact me at the above number.

If you are unhappy with the place that we find with you after you have been discharged, we will discuss your concerns together and involve your nurse, Consultant or Health and Social Care Team or Community Social Worker.

If you are still dissatisfied, you are entitled to have your complaint investigated under the NHS Complaints Procedure. Please contact your Ward Manager if you wish to obtain further details of this procedure.

Following your discharge to one of these homes, the Health and Social Care Team or Community Social Worker will help you to transfer to your home of choice when a place becomes available.

I would like to take this opportunity to offer you my best wishes for the future and to thank you for your co-operation. I hope that you will be happy in your new home.

Yours sincerely

Associate Director of Nursing

Corporate Director – Community Services

Somerset County Council