Outstanding Care,
Compassionate People,
Healthier Communities

DISCHARGE POLICY

	POLICY

Reference	CPG-TW-DP		
Approving Body	Emergency Care Steering Group		
Date Approved	11/3/2026		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
	X		
Issue Date	April-2026		
Version	v5.0		
Summary of Changes from Previous Version	• *Changes to IDAT roles & responsibilities* • *References to SystemOne and Orion replaced by nervecentre* • *Pharmacy section updated* • *Update to Appendix 4 (final discharge letter)*		
Supersedes	Version 4, Issued July 2025 to Review Date November 2025 (12 months from approval)		
Document Category	• Clinical		
Consultation Undertaken	• Head of Discharge • ToCH Manager • Emergency Care Steering Group • IDAT. • MCA lead.		
Date of Completion of Equality Impact Assessment			
Date of Environmental Impact Assessment (if applicable)	Not Applicable		
Legal and/or Accreditation Implications	SFH Legal team if final Choice Policy letter enacted and SFH Safeguarding		
Target Audience	All staff and clinicians working at Sherwood Forest Hospitals Trust and relevant system partners.		
Review Date	April-2029		
Sponsor (Position)	Chief Operating Officer		
Author (Position & Name)	Associate Director of Operations - Urgent and Emergency Care, Janine Foxhall		
Lead Division/ Directorate	Corporate		
Lead Specialty/ Service/ Department	Operations		
Position of Person able to provide Further Guidance/Information	Associate Director of Operations - Urgent and Emergency Care		

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
Effective Discharge Planning Document	***October 2024***

1. Checklist for transfer of patient in private taxi for the purpose of discharge (*documentation/ form to print from intranet for use in practice*) 2. Transfer of Care Standard Operating Procedure 3. Associated leaflets/ letters: • Planning together: leaving hospital when the time is right Fact Sheet (Leaflet A) • You are leaving hospital: returning home Choice Letter B1 • You are leaving hospital: moving or returning to, another place of care Choice Letter B2 • Final Notice Letter (Letter C) • Looking after family or friends after they leave hospital Fact Sheet (Leaflet D) • Planning together: leaving the discharge to assess bed following your period of assessment (Leaflet E) • Assessment completed: returning home (Leaflet F). • Assessment completed: moving or returning to another place of care (Leaflet G) 4. Effective Discharge Planning Document	1. Reviewed with policy v4.0, approved November 2024 2. Under review 2026 3. Reviewed/ new with policy v4.0, approved November 2024 These leaflets/ letters can be found in one document which has been published to the intranet alongside the policy for access/ printing as needed – **see this link**
Template control	June 2020

CONTENTS

1.0 INTRODUCTION

The aim of this policy is to set out how to plan and deliver hospital discharge for our patients; this includes the transfer of care from our hospitals to another care setting.

Sherwood Forest Hospitals NHS Foundation Trust is committed to deliver discharge to assess, home first principles. The national discharge to assess model is built on evidence that the most effective way to support people is to ensure they are discharged safely when they are clinically ready (Medically Safe), with timely and appropriate recovery support if needed.

This policy is to be read in conjunction with the Department of Health and Social Care Hospital Discharge and Community Support Guidance, last published on 26 January 2024.

When implemented consistently, this policy should reduce the number and length of delayed discharges and result in patients being successfully transferred to services or support arrangements where their needs for health and social care support can be met.

2.0 POLICY STATEMENT

The policy provides guidance, sets expectations and describes underlying principles to support staff in the safe discharge and transfer of care of patients. This policy applies to all clinical and operational staff involved in the care and discharge of inpatients over the age of 18 years. There is a separate policy which relates to the discharge of children and young people.

Patients, family and patient representatives should be involved throughout the discharge planning process with the patient's consent and provided with effective information and support during admission. Where a patient is unable to provide consent, necessary checks should be made regarding Lasting Power of Attorney and liaison with Safeguarding services as necessary. Timely and appropriate patient outcomes are critical to optimise patient flow through our hospitals.

Patients, family and or patient representatives will be involved in all decisions about their care, as per the NHS Constitution. Where the patient lacks capacity to make decisions about discharge from hospital, then the application of the policy should be adapted following the Mental Capacity Act 2005.

This policy includes reference to patients with very complex care needs, including those at the end of life.

3.0 DEFINITIONS / ABBREVIATIONS

Item	Definition
CHC	NHS Continuing Healthcare (CHC) is a package of ongoing care for an individual aged 18 or over which is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need'.
Criteria to Reside	A set of medical criteria where the needs can only be addressed within an acute hospital setting. Anyone not meeting the criteria to reside can have their nursing and care needs met in a less intensive environment
D2A	Discharge to Assess (D2A) supports the discharge of people from hospital who are 'clinically stable but require further assessment to establish their ongoing health and social care needs'.
FIT	Frailty Intervention Team (FIT).
IDAT	Integrated Discharge Advisory Team (IDAT)
IMCA	An Independent Mental Capacity Advocate (IMCA) will represent patients assessed as lacking capacity under the Mental Capacity Act 2005 to make important decisions, such as change of accommodation, and who have no family and friends to consult.
LLOS Meeting	Long Length of Stay meeting to address barriers to discharge
MCA	Mental Capacity Act (MCA)
MDT	Multi-Disciplinary Team (MDT) of health and social care professionals involved in the care and assessment of patients
Medically Safe	The patient's condition is such that ongoing assessment, rehabilitation &/or recuperation can continue in a less acute environment away from the King's Mill Hospital Site.
PDMS	Predicted Date Medically Safe. This is the predicted date that a patient no longer needs hospital acute care. Any ongoing assessments, rehabilitation and /or recuperation could continue in a less acute environment. The PDMS is initially based on average length-of-stay data and may change several times in response to the patient's specific needs.
Reablement	The Reablement service, is provided by Nottinghamshire County Council Short-Term Assessment and Reablement Team (START). Reablement is a service provided in the person's own home or care home. It is a goal-focused intervention that involves intensive, time-limited assessment and therapeutic work for up to a few weeks. Ongoing care and support needs will be assessed during this period.
ToCH	Transfer of Care Hub
TTO	To Take Out (Medicines)
SAFER	Senior Review, All patients, Flow, Early Discharge, Review. Five key elements of best practice in safe and timely discharge of patients.

4.0 ROLES AND RESPONSIBILITIES

Role	Responsibilities
Chief Operating Officer	• Overall accountability for ensuring the safe and timely discharge of all patients.
Executive Team, Divisional Leadership Teams, Specialty Triumvirates	• To ensure suitably competent staff are on shift to discharge patients safely and that they are aware of, have access to and implement the policy. • To Act upon incidents arising from patient discharge. • To be a point of escalation for concerns/issues relating to discharge.
Matrons/Head of Discharge/ToCH Manager	• To monitor the safe discharge and action any improvements required to address areas of concern. • To review and develop learning from unsafe or inappropriate discharges. • To be a point of escalation for supported discharge delays/complex discharges. • To monitor staff compliance with using and updating electronic patient records • To attend board rounds to support and identify the reasons behind stays of seven days or more and take appropriate actions
Flow Room, Duty Nurse Managers & Head of Capacity & Flow	• To manage and support flow through the organisation in a timely way. • To liaise with ward staff, IDAT team and the Transfer of Care Hub as necessary, to maximise safe and efficient discharge thus relieving pressure at the front door of the hospital. • To participate in 5 x daily flow meetings, overseeing discharge numbers, delays and bed waiters.
Ward Leaders Therapy Team Leaders Registered Nurses	• To ensure discharge planning is started within 24 hours of admission for all patients setting expectations around Home First • To ensure patients who need support for discharge are flagged for IDAT review at least 24 hours ahead of the patient's Medically Safe date. • To present cases through the long length of stay meeting (LLOS) • To ensure staff have an appropriate understanding of discharge procedures and are aware of this policy. • To communicate with patients, relatives and external partners on matters linked to patient discharge planning. • Where discharge planning is proving to be difficult ward leaders should work with the IDAT team to make decisions and communicate them to patients and carers. • To provide patients with adequate information pre-discharge and contact details in case of difficulties post-discharge. • To complete discharge planning documentation. • To make patients ready ensuring TTOs, equipment and transport are prepared/booked in advance. • To check the medicines supplied against the TTO following the process defined in the Trust wide Medicines Policy.

	• In the absence of IDAT nurse, registered nurses or therapists can undertake MCA for patients requiring supported discharge. See appendix 3.
Consultants & Medical Teams	• Consultants will adhere to the to the SAFER Care Flow Bundle, documents which can be found on the Intranet. • To lead twice daily board rounds (morning board round to start no later than 9am) and subsequent ward rounds for all Acute beds. • To confirm patients are Medically Safe and ensure clinical systems are updated. • To ensure all members of the MDT have a voice and are involved in PDMS setting. • To escalate discharge delays to senior operational team in division. • To ensure all delays within the control of the ward team are addressed i.e., TTO's, electronic discharge letter, etc. • Assess the patient's Criteria to Reside, ensure clinical systems are updated, and take appropriate action. • Once the MDT has deemed that a patient no longer meets the Criteria to Reside, the ward team will be responsible for discharging patients.
Head of Discharge	• Continuous service improvement, with emphasis on embedding the 'home first' approach in line with the Discharge to Assess model. • Ensuring high quality and timely completion of D2A documentation by IDAT. • To be a point of escalation for supported discharge delays/complex discharges or delayed discharges. • To further escalate unresolved discharge issues.
Integrated Discharge advisory team (IDAT) IDAT Nurses, Discharge Co-ordinators & IDAT Admin	• To maintain an overview of all patients identified as requiring a supported discharge. • To complete the D2A referral, ensuring that information is accurate for the discharge pathways. • IDAT nurses to complete MCA for patients requiring supported discharge who cannot consent to the D2A process. • To ensure relevant supported discharge information is updated on the appropriate clinical systems. • To ensure the timely triage of all complex patients within the ToCH • To be a point of support for multi-agencies with the discharge of complex cases where needed. • Escalate discharge related concerns to the Head of Discharge/ToCH Manager as appropriate. • To attend daily flow meetings as required and present the following information: o Number of supported discharges from KMH o Number of people accepted into P2 capacity o Number of supported discharges from peripheral (not P2) beds

	○ The above 3 metrics should total a minimum of 20 per day Monday – Friday ○ Number of people with a pathway decision from each daily triage ○ Number of patients MSFD over 24 hours The use of existing peripheral beds is currently under review. Current proposals include use of Oakham & Lindhurst wards exclusively for P2 patients with further P2 capacity available in 12 Sconce beds. It is further proposed that the IDAT Team will assume full responsibility for the flow into and out of Oakham, Lindhurst and 12 designated beds on Sconce. Work is underway on Nervecentre to facilitate this. It is anticipated that National Community Sit rep completion will commence on 01/04/2026. Current peripheral capacity is used as follows: ○ Oakham Ward MCH P2 ○ Lindhurst Ward MCH P2 ○ Castle Ward NWK Medically Fit (bridging) ○ Sconce Ward NWK sub acute + 12 P2 beds ○ Ashmere Care Home Medically Fit (bridging) 15 beds (further 5 beds available as winter capacity)
Pharmacy Staff	• To dispense TTOs in a timely manner in accordance with agreed KPIs. • Work with wards/flow team to prioritise TTOs. • Escalate TTO delays to the Capacity & Flow team. • Ensure that appropriate and sufficient medication has been dispensed on discharge to allow time for the patient or carers to obtain further supplies from their GP following the Nottinghamshire Area Prescribing Team prescribing policy, which will usually mean a minimum of 10 days' supply. • Ensure medicine and dispensing information is up to date on the appropriate clinical systems. Patients should not normally be discharged without their TTO medicines and discharge letter. In exceptional circumstances medicines may need to be collected from the discharging ward after the patient has been discharged. In these circumstances the person collecting should be pre-agreed and their identity confirmed when they collect the medicine. Any other arrangements should be approved by the Duty Nurse Manager or via the Flow Room to arrange transport of medicines.
Front Door Team (including FIT Team)	• To complete front door assessments to avoid admission. • To ensure patient safety at home, referring to community services as required. • FIT team nurses to complete MCA for patients requiring supported discharge who cannot consent to the D2A process. • To highlight complex patients to the ToCH. • To highlight any homelessness or out of area patients to ToCH

	• Linking with IDAT to support discharges and completion of D2A.
Transfer of Care Hub (ToCH)	• Ensure that all D2A referrals are triaged in a timely manner, as a minimum twice daily to avoid delays in discharge. Agree a minimum of 20 pathways per day Monday – Friday. • Identify the correct level of care required for the patient to be discharged safely. • To confirm discharge plan within 24 of patient being medically safe. • To agree, allocate and record the discharge pathway for all complex discharge patients. • To escalate delays/discharge concerns to the ToCH Manager/Head of service for discharge. • Communicate with the ward team to confirm discharge pathway, start date of care package or date of transfer to alternative bed.
Transfer of Care Hub Manager	• Continuous Improvement of systems and processes. • Embedding and monitoring of D2A model. • Identifying themes delaying discharges. • Working with internal and external partners to unblock discharge pathways. • Offering appropriate professional challenge regarding triaging decisions. • Escalating any complex discharges that cannot be resolved in the hub. • Develop learning from case studies with IDAT team and cascade to system partners.

5.0 APPROVAL

Following consultation with:

- Nottinghamshire Integrated Care System (ICS) Integrated Discharge Lead
- Transfer of Care Hub (ToCH) Manager
- Integrated Discharge Advisory Team (IDAT)
- Associate Director of Operations- Urgent and Emergency Care.
- Corporate Nursing

The policy is approved by the Emergency Care Steering Group.

6.0 DOCUMENT REQUIREMENTS

There are a series of ICB approved documents, Choice Policy, for patients and carers to support them to prepare for discharge following an acute stay. Examples of these can be found at Appendix 4. The final document is a template only and can be amended to suit the Trust/patient needs. Hard copies of the standard documents can be found on each ward for distribution to patients and families.

The Discharge to Assess (D2A) document is completed outlining patients' needs for a safe discharge. This document, when completed, includes information regarding the patient's pre-admission and

current functional status. When completed accurately it will fully describe a patient's discharge needs and enable the ToCH to decide the appropriate discharge pathway.

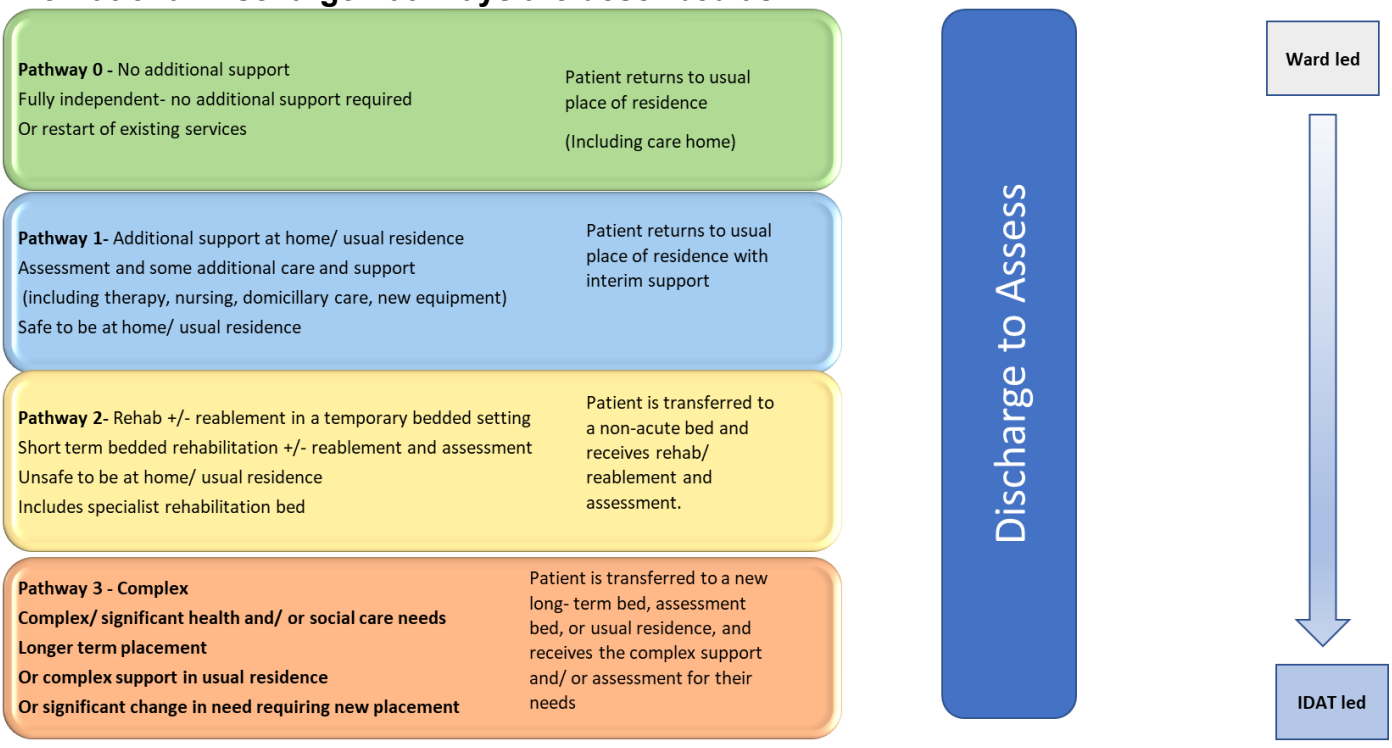
7.0 DISCHARGE PATHWAYS

All patients should be discharged on the most appropriate Discharge to Assess pathway, at least 95% of people will be discharged home. Discharges are described as 'simple' or 'supported'.

Simple discharges are ordinarily managed by the admitting ward and will follow the definition of Pathway 0 as described below. Nevertheless, because a person does not require additional support once discharged this does not necessarily mean that there are no barriers to discharge. At present where an admitted patient does not require onward care but does have other issues which may cause a delay to discharge then they are classed as P0+.

Whilst this is not a nationally recognised pathway it currently differentiates those patients who may require more complex discharge planning. In these cases, ward staff are advised to contact Transfer of Care Hub to either discuss discharge options or else seek support in arranging discharge.

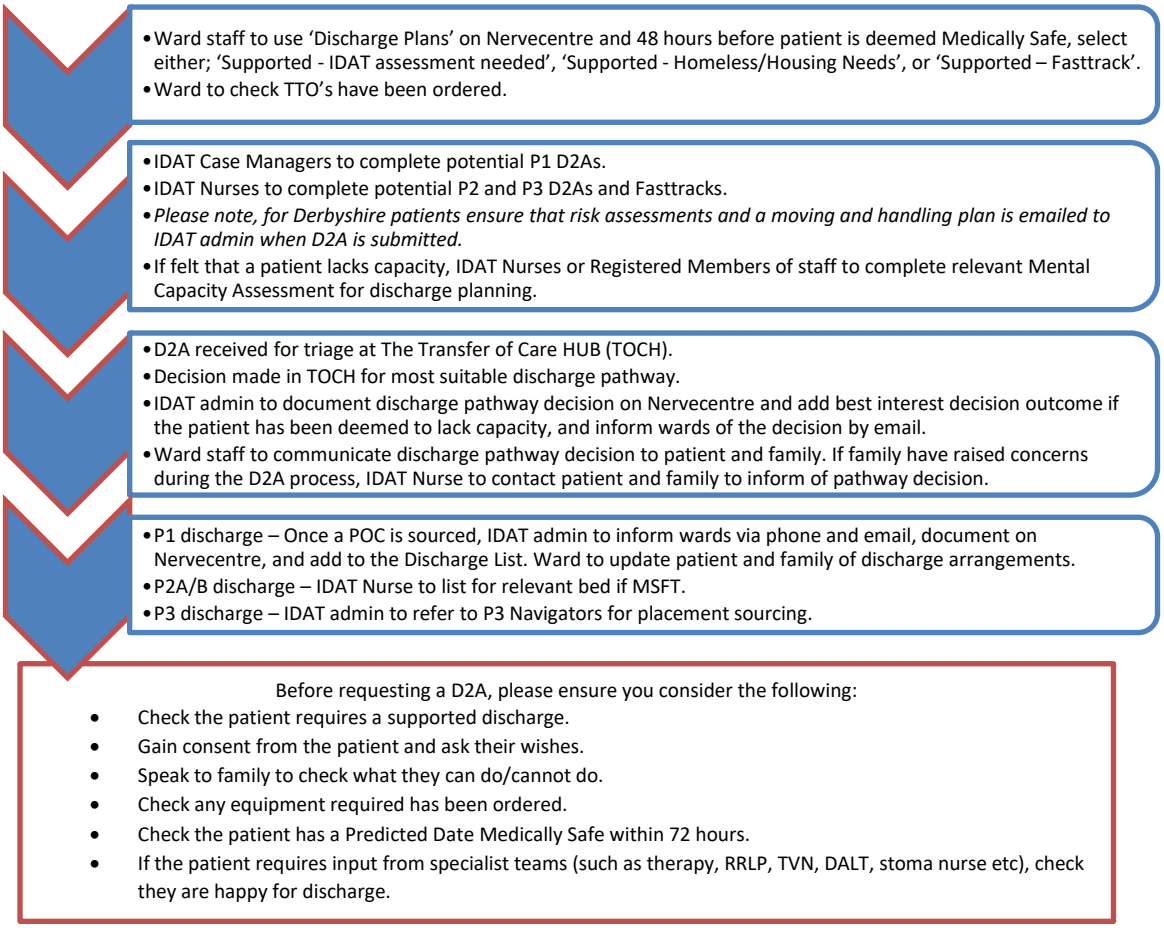
The National Discharge Pathways are described as:



The discharge of patients on Pathways 1 to 3 (supported discharges) is led by the Integrated Discharge and Assessment Team, IDAT team and the Transfer of Care Hub (ToCH). The ToCH currently includes colleagues from IDAT, Adult Social Care, Short Term assessment and Reablement Team (START), Community Therapy, Nottinghamshire Healthcare Trust, Age UK, Home From Hospital.

7.1 SUPPORTED DISCHARGE PROCESS

The process outlined below is our current way of working. This process will be reviewed as discharge delay themes are identified and refined accordingly. Any amendments to the process will be reflected in future versions of this document.



7.2 TRANSFER OF CARE HUB PROCESS

The ToCH will triage all supported discharge referrals and determine which pathway will be the most appropriate to meet the needs described on the D2A form following a multi-disciplinary discussion.

Pathway 1 patients will be allocated to the most appropriate reablement or care provider with available capacity and the decision updated on Nervecentre by IDAT admin.

Pathway 2 patients will be listed for the most appropriate, available P2 bed in the area, most local to the patient's home address. P2 capacity for Mid Notts is provided on Oakham & Lindhurst Wards and on 12 designated beds on Sconce Ward, Newark. For patients requiring P2 inpatient rehab, LOS should be no longer than 15 days. For those requiring a period of further assessment, LOS should be no longer than 29 days.

Pathway 3 patients will be emailed to the Pathway 3 Navigators to source the most appropriate nursing bed.

Where there is insufficient information to make a safe decision about the discharge pathway, the IDAT team will gather the information needed. Where this isn't possible, the IDAT team will speak to the relevant ward, update the D2A referral ready for the next triage and update Nervecentre as necessary. Ideally, all amendments should be made within the same working day to avoid delaying discharge.

7.3 PATIENTS' RIGHTS AND RESPONSIBILITIES

Patients do not have the right to remain in hospital once they are deemed not to meet the criteria to reside, as per the ICB Choice Policy (2023). This includes occasions where the appropriate level of care cannot be sourced to support a discharge home. In these circumstances, interim care in a care home may be provided until such time as home support can be sourced.

As part of the normal discharge process patients will receive letters A and B1 or B2 of the Choice Policy as required.

For those occasions where a patient has been deemed to not meet the criteria to reside, but refuses to leave:

- The patient must be formally asked to leave by the Nurse in charge/Ward Manager.
- If no resolution can be found, the Matron and then the Divisional Director of Nursing (as required) will speak to the patient and their carers. If no agreement has been reached a Final Notice Letter from the ICB Choice Policy will be issued. It is expected that this letter will only be seldom enacted and only when all other possible avenues have been exhausted. (Letter C). This letter will be delivered only by either the Divisional Director of Nursing or their nominated deputy.
- If there is still no resolution, the Divisional Director of Nursing and Associate Director of Operations will consult with the Trust's Legal Team. Whilst system partners have signed up to the suite of letters, it remains the individual Trust's decision about whether it is appropriate to enforce them.
- The patient will be provided with the details of the Patient Experience team, with information on the complaints and appeals procedures throughout the process.
- The process detailed above can be seen in Appendix 5.

7.4 MENTAL CAPACITY ASSESSMENT

The Mental Capacity Act (MCA, 2005) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over.

Patients will be assumed to have mental capacity unless there are reasons to suspect otherwise, at which time an MCA will be completed.

A patient with mental capacity cannot insist on staying in hospital or a discharge to

assess pathway after they no longer meet the criteria to reside and so this is not an option for a patient who lacks mental capacity for the discharge decision.

Where a patient, despite all reasonable efforts to support them, lacks mental capacity for discharge decisions, the decision must be made in their best interests. (Mental Capacity Act (MCA) 2005. **See appendix 3 for MCA process for supported discharges.**

Refer to Mental Capacity Act Policy

7.5 INFORMATION TO BE GIVEN TO THE PATIENT OR CARERS ON DISCHARGE (CARER ONLY IF WITH CONSENT OF PATIENT OR IF HAS LEGAL POA)

- Medical Discharge Summary Letter with a copy to patient/GP/pharmacy/healthcare records and any follow up appointments
- Any relevant patient information leaflets for signposting to external agencies.
- Any relevant information/literature relating to patient self-care plan.
- Fit note if appropriate.

Where patients and carers need to be trained to use equipment. It is the ward team's responsibility to ensure training is properly provided and there is an agreed level of competency ahead of discharge.

7.6 ITEMS TO BE GIVEN TO THE PATIENT OR CARERS ON DISCHARGE (CARER ONLY IF WITH CONSENT OF PATIENT OR IF HAS LEGAL POA)

- All patient property should be returned to patient on discharge.
- A 7-day supply of consumables to support ongoing care and treatment in the community. (Ward staff to refer to the local discharge checklist as a guidance).
- TTOs (Medication, nutritional supplements, feeds, thickening products).

7.7 INFORMATION TO BE GIVEN TO THE RECEIVING HEALTHCARE PROFESSIONAL

Within 24 hours of the patient's discharge, the patient's GP is sent an electronic discharge summary by the discharging ward. This is currently sent via nervecentre (Electronic Clinical Recording System). All relevant healthcare professionals are informed of any discharge against hospital advice (self-discharge) so that continuing treatment can be resumed.

7.8 TRANSPORT

Wherever possible, patients should be encouraged to make their own way home with a family member or trusted friend. Patients can wait in the discharge lounge to be collected by their family member or friend where appropriate. As a minimum all transport requests should be made ahead of the Medically Safe date as routinely as possible.

Staff must arrange transport for patients according to their need and eligibility. This will usually be via family or carers, voluntary sector, or taxi. In the event a patient cannot be collected by family/ friend and hospital transport is not available same day, then an assessment can be made for

fitness/suitability to transport in a private taxi, whilst waiting in the discharge lounge. An assessment checklist must be completed by the discharging ward (Checklist for transfer of patient in private taxi for the purpose of discharge.)

Where hospital transport is required, the wards should book by 20.00hrs on the day prior to discharge or with as much notice as possible. Patients booked by 20.00 hrs the day before discharge will be able to select a timed slot and will not have to be 'made ready' on the electronic system. For those booked either after 8pm the day before or on the day of discharge, staff will need to make the patients 'ready' on the transport system once TTOs are complete and the patient is ready to travel.

This alerts the transport crew to then collect the patient. Where urgent transport is required to facilitate same day discharge or a special journey, the ward can contact the Flow Room site management team to support this.

Transport for Bariatric patients, those with access issues and all patients from out of area should be booked 48 hours prior to discharge. Relevant funding discussions must be held with divisional budget holders.

IMPORTANT – Transport funding is very limited as is capacity. Please follow the points below:

- **Always check whether patient can make their own way before offering hospital transport.**
- **If hospital transport required, ensure that minimum level requested (ie chair not stretcher)**
- **Ward staff should be trained in transport booking and only request it through the Flow Room for complex bookings.**
- **Wards do not have any budget for transport. Any bookings made are funded via the central pot held by Site Management Team.**

7.9 PATIENT DISCHARGE LOUNGE

All adult patients should be promptly transferred to the patient Discharge Lounge to await discharge unless there is a clinical reason not to do so.

Where a patient is identified as Medically Safe for transfer and a discharge plan is in place, the ward should indicate this on the relevant field on the appropriate electronic patient records/Nervecentre.
The discharge lounge team will review all the patients listed to determine suitability for transfer to the discharge lounge, as appropriate following eligibility risk assessments. In periods of escalated OPEL level wards should ensure that patients are moved to the Discharge Lounge within 30 minutes of allocation.

7.10 DISCHARGE AGAINST HOSPITAL ADVICE AND SELF DISCHARGE

Patients may decide to discharge themselves from the hospital against clinical advice.
If a patient wishes to self-discharge:

- Staff must advise the patient of the reasons why it is in their best interest to remain in hospital.

- The ward must document that the patient wishes to self-discharge clearly within the discharge summary on nervecentre (Electronic Clinical Recording System). They also will ask the doctor in charge to update the medical notes and complete an MCA if there is any doubt that the patient lacks capacity.
- The doctor 'on call' must inform their consultant as soon as possible.
- Any medication required for discharge must be provided. If the patient refuses to wait for their medication, then all reasonable steps must be taken to ensure that the patient receives it, e.g., using a courier service to deliver the medications to their usual place of residence, and documentation made in the patient's notes and communicated to the GP indicating that the patient has left without medication as per the Medicines Policy.
- Where appropriate relatives and Social Services must be contacted.
- A discharge summary must be sent to the GP within 24 hours of the patient leaving hospital.
- The Duty Nurse Managers must also be informed if 'out of hours.'

7.11 DISCHARGE ARRANGEMENTS FOR HOMELESS PATIENTS/ HOUSING ISSUES

Homeless patients are at high risk of readmission if discharged without appropriate accommodation.

In accordance with the Department of Health & Social Care Guidance (DH 2018) and the Homelessness Reduction Act (2017), admitting clinicians must identify homeless patients on admission and have a 'Duty to Refer' them via the Duty to Refer Checklist which forms part of the above act.

Safe and effective discharge of homeless patients

The specific needs and rights of homeless individuals and the range of services available to them are important fundamentals in providing informed, effective, and compassionate care.
It is crucial to work in partnership across health, social care, housing, and the voluntary sector to best support homeless patients and ensure, once medically fit, they are safely discharged to an appropriate setting.

Meeting the duty to refer

The Homelessness Reduction Act 2017 places a duty on hospital trusts, emergency departments and urgent treatment centres to refer people who are homeless, or at risk of becoming homeless within 56 days, to their local authority.

Hospital staff need to request Street health who will assess their suitability for a 'Duty to Refer' to activate the homeless referral. Any other housing issues should be identified as early as possible by ward staff and a D2A requested so IDAT can start their assessments. Patients deemed not to have mental capacity regarding discharge planning will be referred to Adult Social Care.

7.12 SPECIALIST HEALTH EQUIPMENT

Specialist health equipment may be essential for discharge from hospital. Entitlement to provision is determined as part of the multi-disciplinary assessment and care planning process and is based on the clinical needs of the patient.

Patients and their carers will be trained in the use and care of any equipment provided by the trust and be given a contact number in case of failure or concern.

- Registered Nursing homes providing nursing care should provide an appropriate level of equipment for prevention and treatment as defined by current legislation (Care Standards Act 2000).
- People at home or in residential care are entitled to appropriate health and social care equipment as determined by assessed need and provided by the community equipment service.

7.13 INFECTION PREVENTION AND CONTROL

The operating policy for infection prevention and control (2025) provides details with regards to discharge of patients and infection control requirements.

7.14 DISCHARGE ARRANGEMENTS FOR PATIENTS AT THE END OF LIFE

A fast-track discharge is for patients with a rapidly deteriorating condition that may be entering a terminal phase of their illness. As a result of this decision, the patient may require 'fast tracking' for immediate provision of NHS Continuing Healthcare funding to fund a placement or a package of care to facilitate a rapid discharge.

The process for Fast Track is as follows:

- The medical team caring for the patient should discuss the pathway with the patient and/or family/carers and document the discussion in the patients notes.
- Clearly state why they feel the patient's condition qualifies for fast track.
- Medical team to complete the fast-track tool (Part 1 paperwork) and refer through the appropriate electronic patient records to IDAT.
- IDAT nurse to complete second part of assessment which details the care needs of the patient. (Part 2 paperwork)
- IDAT to apply for fast-track funding at the daily call to assist with a timely discharge and follow each case through to the point of discharge.
- IDAT nurse will work with the patient and family to source an appropriate nursing home or care package in the community.
- IDAT to arrange transport.

8.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g., Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (e.g. verbal, formal report etc) and by who)
Discharge Policy implementation	Associate Director of Operations - Urgent & Emergency Care, Hub Manager, IDAT team, Matrons, Ward Leaders and Capacity & Flow Team	Monitoring of: • MEDICALLY SAFE patient numbers and delayed discharges • Long Length of Stay patients	Daily review of delayed discharges and twice weekly review of long length of stay patients.	LLOS Meetings Emergency Care Steering Group
Complaints and Compliments	PET team	Monthly reports	Monthly	Divisional Governance
EQIA – Appendix 1	Associate Director of Operation - Urgent & Emergency Care	Document review	Annually or when there is significant change	Emergency Care Steering Group

9.0 TRAINING AND IMPLEMENTATION

To date there has been no formal dissemination of or training in this policy. However, following the approval of this policy, the Associate Director of Operations – Urgent and Emergency will be accountable for the required support and training to be provided to ward and discharge teams to embed the discharge policy.

10.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment (see completed form at Appendix 1)
- This document is not subject to an Environmental Impact Assessment.

11.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- Department of Health and Social Care Hospital Discharge and Community Support Guidance published in (January 2024)
- ECIST SAFER Care Bundle, NHS Improvement, '*The Rapid improvement guide to the SAFER patient flow bundle'* accessed [Online 08/09/2023]
- ECIST Reducing Long Length of Stay Accessed [Online 12/09/2023]
- Health and Social Care Act (2020)
- Mental Capacity Act (2005)
- National institute for Health and Care Excellence
- Social care institute for Excellence: Assessment of needs under the Care Act (2014)
- The Department of Health *'The NHS Constitution for England' (2023)* The NHS long term plan (2019) Nottingham and Nottinghamshire ICS Partners in Health and Adult Social Care: Discharge ICB Choice Policy (2023)
- NHS continuing healthcare fast-track pathway tool.

Related SFHFT Documents:

- SFHT Mental Capacity Act (MCA) Policy (v6.0, March 2023)
- Missing Service User Joint Policy and Procedure (v3.0, July 2023) **(**MISPER Policy)
- SFHT Adult patient flow and escalation policy (June 2022)
- SFHT Medicines policy V1.182 (2021)
- Patient assessment for suitability for taxi transport home SOP 2.0 (June 2021)

12.0 KEYWORDS

Transfer; integrated; TTO; taxi; process; planning; NHS Continuing Healthcare; home; Medically Safe; PDMS; MCA; Criteria reason to reside; Fast-track; Choice Policy; interim; intermediate; home; of care hub; SAFER; ToCH,

13.0 APPENDICES

Appendix 1 – Equality Impact Assessment
Appendix 2 – Reason to reside checklist
Appendix 3 – MCA process for supported discharges.

APPENDIX 1 - EQUALITY IMPACT ASSESSMENT (EIA) FORM (PLEASE COMPLETE ALL SECTIONS)

EIA Form Stage One:

Name EIA Assessor: Yvonne Simpson	**Date of EIA completion: January 2026**
Department: Corporate	**Division: N/A**
Name of service/policy/procedure being reviewed or created: Discharge Policy	
Name of person responsible for service/policy/procedure: Janine Foxhall – Associate Director of Operations – Urgent & Emergency Care	
Brief summary of policy, procedure or service being assessed: The aim of this policy is to set out how to plan and deliver hospital discharge for our patients; this includes the transfer of care from our hospitals to another care setting.	
Please state who this policy will affect: Patients or Service Users, Carers or families, Commissioned Services, Communities in placed based settings, Staff, Stakeholder organisations.	

Protected Characteristic	Considering data and supporting information, could protected characteristic groups' face negative impact, barriers, or discrimination? For example, are there any known health inequality or access issues to consider? (Yes or No)	Please describe what is contained within the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening. Please also provide a brief summary of what data or supporting information was considered to measure/decipher any impact.
Race and Ethnicity	No	• This policy is appropriate for all race and ethnicities. Interpreters will be made available on wards as required to support understanding. • All CHOICE letters come in a range of languages and can be requested from the Integrated Care Board (ICB) • All genders are included within the policy • This policy will support all ages groups to ensure no assumptions are made • This policy will support all disabilities. • This policy will support sexuality characteristics. • This policy will support pregnancy and maternity characteristics. • This policy is appropriate for persons having undergone gender reassignment • This policy supports the socio-economic factors of the population the Trust serves.
Sex	No	
Age	No	
Religion and Belief	No	
Disability	No	
Sexuality	No	
Pregnancy and Maternity	No	
Gender Reassignment	No	

Marriage and Civil Partnership	No	Data/Information used to support this was taken from the Population Census and Nottingham and Nottinghamshire ICS Discharge Choice Policy.
Socio-Economic Factors (i.e. living in a poorer neighbour hood / social deprivation)	No	

What consultation with protected characteristic groups including patient groups have you carried out?

- Consultation with Adult Health and Social Care and ICB Nottinghamshire Health Care NHS Foundation Trust.
- Equality, Diversity & Inclusion Lead

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? No

On the basis of the information/evidence/consideration so far, do you believe that the policy / practice / service / other will have a positive or negative adverse impact on equality? (delete as appropriate)

	Positive	
High	**Medium**	**Low**

If you identified positive impact, please outline the details here: The Policy is designed to ensure that the necessary procedures and practices are established across the Trust to allow all patients a safe, well communicated and timely discharge.

Signature:

I can confirm I have read the Trust's Guidance document on Equality Impact Assessments prior to completing this form

Date: January 2026

Please send the complete EIA form to the People EDI Team for review.
Please send the form to: sfh-tr.edisupport@nhs.net

APPENDIX 2 – REASON TO RESIDE CHECKLIST

Criteria to reside – maintaining good decision making in acute settings

Every person on every general ward should be reviewed on a twice daily ward round to determine the following. If the answer to each question is 'no', active consideration for discharge to a less acute setting must be made:

• Requiring ITU or HDU care?

• Requiring oxygen therapy/NIV?

• Requiring intravenous fluids?

• NEWS2 > 3? (Clinical judgement required in persons with AF and/or chronic respiratory disease)

• Diminished level of consciousness where recovery realistic?

• Acute functional impairment in excess of home/community care provision?

• Last hours of life?

• Requiring intravenous medication > Breakfast & Dinner (including analgesia)?

• Undergone lower limb surgery within 48 hours?

• Undergone thorax-abdominal/pelvic surgery with 72 hours?

• Within 24 hours of an invasive procedure? (with attendant risk of acute life-threatening deterioration)

Clinical exceptions will occur but must be warranted and justified. Recording the rationale will assist meaningful, time efficient review.

Review and challenge questions for the clinical team

Is the person medically optimised? Do not use 'medically fit' or 'back to baseline'.
What management can be continued as ambulatory, for example heart failure treatment?
What management can be continued outside the hospital with community/district nurses? For example, IV antibiotics?

Persons with low NEWS (0-4) scores – can they be discharged with suitable follow up?

• if not scoring 3 on any one parameter – for example, pulse rate greater than 130

• if their oxygen needs can be met at home

• stable and not needing frequent observations every 4 hours or less

• not needing any medical/nursing care after 8pm:

• people waiting for results – can they come back, or can they be phoned through?

• repeat bloods – can they be done after discharge in an alternative setting?

• people waiting for investigations – can they go home and come back as outpatients with the
same waiting as inpatients?

Appendix 3 - MCA process for supported discharges.

Ward Process

- Ward to identify and manage **Pathway 0** Discharges. IDAT referral not required. Ward nurse to document Consent/Capacity.
- Ward identify that a patient requires referral to IDAT however has reason to believe the patient may lack capacity. Ward nurse to document Consent/Capacity for Referral to IDAT for assessment. This can be recorded within the Nursing Evaluation or as part of the MCA Form 1 Care Planning documentation.

D2A Joint Assess-ment Process

Pathway 1, 2a, 2b, 3

- Patients who are unable to consent to the discharge to assess process will require a mental capacity assessment (MCA) to evidence this. IDAT Band 6/7, should complete the MCA regarding 'Discharge Process'. In the absence of the IDAT team a registered nurse or therapist to complete the MCA. At the point of D2A pathway discussion/assessment, the IDAT team / or registered staff can explain the multiple discharge pathways to the patient and or family.
- If a patient has been identified as requiring ongoing rehab and does not have capacity to consent to this pathway, the mobility section of the D2A will be completed by PT/OT team on the ward, including if the patient consents to rehab or evidence of best interest decision. PT/OT referral to IDAT on nerve centre for the completion of the care and support needs and MCA Re: D2A Process.

Hub

- Hub Triage the D2A Referral.
- Discharge pathway decided by the Hub MDT, this is recorded on Nerve Centre by the IDAT admin team.
- Hub documentation on Nerve Centre to include the decision making process for all referrals. To identify the best interest decision making for those who lack capacity.
- Hub admin team feed back to ward departments re: discharge plans via Nerve centre and/or telephone.

Appendix 4 - Associated Leaflets & Letters

Sherwood Forest Hospitals NHS Foundation Trust

ASSOCIATED LEAFLETS and LETTER TO THE SFH DISCHARGE POLICY in collaboration with:

HM Government | NHS | NHS Nottingham and Nottinghamshire | Integrated Care System Nottingham & Nottinghamshire

- **Except for letter C, if you run out of hard copy leaflets in your clinical area please print from this document as needed**
- **If 'C – Final notice letter' is required, please liaise with the Discharge Team/ Divisional Director of Nursing or their nominated deputy**

scription		Print Page(s)
Planning together: leaving hospital when the time is right	Leaflet A	2
You are leaving hospital: returning home	Letter/ leaflet B1	3-4
You are leaving hospital: moving or returning to another place of care	Letter/ leaflet B2	5-6
Final notice letter (representational copy)	Letter C	7-8
Looking after family or friends after they leave hospital	Leaflet D	9-10
Planning together – Leaving D2A bed following your period of assessment	Leaflet E	11
Assessment completed – returning home	Leaflet F	12
Assessment completed – moving or returning to another place of care	Leaflet G	13

SFH Document Control:

Approved by (committee/ group):	Trust Management Team	**Issue Date**	Nov-2024
Date Approved:	Nov 2024	**Review Date (for SFH intranet/ central records)**	November 2025 (same as SFH Discharge Policy)
Document Contact	Associate Director of Operations - Urgent and Emergency Care, Janine Foxhall	Keywords:	Same as SFH Discharge Policy

HM Government

NHS

Planning together: leaving hospital when the time is right

This leaflet explains why it is important to start planning for you to leave hospital

Why are we starting to plan for me to leave hospital?

Our top priority is to help you get better and support you to leave hospital when the time is right. You will only leave hospital when you no longer need hospital care and it is safe to do so. It is important that, together, we start planning right away to ensure you leave hospital in a safe and timely manner.

In most cases, you will return home. You might need some additional care to help you in your recovery, or practical support such as help with shopping. If you are a care home resident you will most likely return to your care home. If you require more complex care and support this could be in another bed in a community setting.

What might I expect?

Early conversations – Soon after you arrive in hospital we will discuss and plan how you will be able to leave. We will involve your carers, family and/or friends in conversations if you would like them to be included.

'Expected date of discharge' – Soon after you arrive in hospital you will be given an 'expected date of discharge' (expected date you will leave hospital) which will be reviewed during your stay.

What matters most to you to be considered – The team caring for you will ask 'what matters most to

Questions to ask during your hospital stay:

1. What is the main reason I am in hospital for?
2. What is going to happen to me today and tomorrow?
3. What extra help might I need when I leave hospital?
4. When will I be able to leave hospital?

you?’. They will ensure this is considered when planning for you to leave hospital.

HM Government

NHS

You are leaving hospital: returning home

This leaflet explains why you are leaving hospital and what you might expect after you have left.

Why am I leaving hospital?

The team caring for you have agreed that you no longer need hospital care and it is safe for you to return home to continue your recovery.

Why can't I stay in hospital?

When you no longer need hospital care, it is better to continue your recovery out of hospital. Staying in hospital for longer than necessary may reduce your independence, result in you losing muscle strength or expose you to infection. Leaving hospital when you are ready is not only best for you but will free-up a bed for someone who is very unwell.

Our top priority is to ensure you are in the right place at the right time for the best recovery possible. The best place for you right now is at home where you can continue to recover in a familiar environment.

What might I expect?

The team caring for you will discuss transport and other arrangements with you (and your carers, family and/or friends if you wish). If you have coronavirus you will be provided with relevant advice.

If you need more care and support now than when you came into hospital, the team caring for you will discuss options for how you receive that care and support following discharge. The team will also discuss when you should be assessed for the provision of any long-term care and support. You may be required to contribute towards the cost of your care and support, if you need it.

Who can I contact?

After you have left hospital, if you need to speak to someone, please contact:

Financial support

Following the period of recovery, rehabilitation and/or reablement, an assessment of your needs will be carried out to determine your eligibility for any ongoing services provided by Adult Social Care.

If following this assessment you are eligible for support (and you wish to proceed), it will be necessary to establish how much you can afford to contribute towards the cost of this care/support.

A financial assessment will be completed which takes into consideration your income and expenditure together with any savings or investments that you may have. If you have savings or investments above £23,250 (not including the value of the property that you live in), you will be required to pay the full cost of any ongoing care/support.

Further information about the financial assessment and the charging policy can be found at:

Nottingham City Residents

https://nottinghamcity.gov.uk/information-for-residents/ health-and-social-care/adult-social-care/money-andlegal-matters/finance-fairer-charging/

Nottinghamshire County Residents

www.nottinghamshire.gov.uk/care/adult-social-care/social-care-publications/paying-for-support

HM Government

NHS

You are leaving hospital: moving or returning to another place of care

This leaflet explains why you are leaving hospital and what you might expect after you have left.

Why am I leaving hospital?

The team caring for you have agreed that you no longer need hospital care and it is safe for you to move to another place of care to continue your recovery.

Why can't I stay in hospital?

When you no longer need hospital care, it is better to continue your recovery out of hospital. Staying in hospital for longer than necessary may reduce your independence, result in you losing muscle strength or expose you to infection. Leaving hospital when you are ready is not only best for you but will free-up a bed for someone who is very unwell.

Our top priority is to ensure you are in the right place at the right time for the best recovery possible. The best place for you right now is a bed in the community which can best meet your needs at this time. If you are a care home resident this will most likely be your care home.

What might I expect?

The team caring for you will discuss transport and other arrangements with you (and your carers, family and/or friends if you wish). If you have coronavirus you will be provided with relevant advice.

If you need more care and support now than when you came into hospital, the team caring for you will discuss options for how you receive that care and support following discharge. The team will also discuss when you should be assessed for the provision of any long-term care and support. You may be required to contribute towards the cost of your care and support, if you need it.

Who can I contact?

After you have left hospital, if you need to speak to someone, please contact:

Financial support

Following the period of recovery, rehabilitation and/or reablement, an assessment of your needs will be carried out to determine your eligibility for any ongoing services provided by Adult Social Care.

If following this assessment you are eligible for support (and you wish to proceed), it will be necessary to establish how much you can afford to contribute towards the cost of this care/support.

A financial assessment will be completed which takes into consideration your income and expenditure together with any savings or investments that you may have. If you have savings or investments above £23,250 (not including the value of the property that you live in), you will be required to pay the full cost of any ongoing care/support.

Further information about the financial assessment and the charging policy can be found at:

Nottingham City Residents

https://nottinghamcity.gov.uk/information-for-residents/ health-and-social-care/adult-social-care/money-andlegal-matters/finance-fairer-charging/

Nottinghamshire County Residents

www.nottinghamshire.gov.uk/care/adult-social-care/social-care-publications/paying-for-support

Representational letter – **DO NOT USE** – please liaise with discharge team for one to provide for use in practice

We are currently creating some revised templates for use. This policy will be updated as soon as these have been approved.

Integrated Care System
Nottingham & Nottinghamshire

Insert date

Dear Sir/Madam

Your occupation of a bed on [insert ward]

We write to set out [Insert Acute Hospital/D2A pathway NHS Trust] (the "Trust") concerns regarding your continued occupation of a bed on the [insert ward] (the "Ward") at [Insert Acute Hospital/D2A pathway NHS Trust] (the "Hospital"), and to confirm that the Trust considers you are medically fit for discharge.

You have been informed that you are medically fit for discharge. I refer you to the latest discussion you had on [**insert date(s) and name of staff member who led the discussion with the patient**]. The support you will require after your discharge has been assessed and you will need [**insert brief details of discharge plan**]. This support has been put in place by the Trust and [**insert any other bodies involved in the aftercare arrangements**]. To date, you have refused to leave in accordance with the options for support that the Trust and other organisations have provided to you.

As an inpatient at the Hospital, you had an implied licence from the Trust to enter and remain on the Trust's premises for the period when you required inpatient treatment. However, on/in [**insert date or month as appropriate**], the Trust took the decision that there was no medical reason for you to remain at the Hospital and began making arrangements for you to be discharged from the Ward.

Since that date, there have been numerous discussions about your health and social care needs in order to determine the appropriate services to be offered to you. The Trust has reconfirmed its decision that there is no medical reason for you to remain as an inpatient on the Ward at various points since [**insert date**]. You have nevertheless refused to co-operate with the multi-agency discharge process and yet remain fit for discharge from the Ward.

Your bed is urgently required for the delivery of the Trust's specialist healthcare services to other patients. It is not appropriate for you to remain on the Ward. The Trust has therefore requested on a number of occasions that you vacate your bed at the Hospital, but you have refused to move to the suitable alternative arrangements which have been identified for you.

In light of the above, if you continue to refuse to co-operate with the multi-agency discharge process, the Trust will have no choice but to withdraw your implied licence to enter and remain on the Trust's premises; at which point you would be deemed a trespasser. The next step after this would be for the Trust to issue Court Proceedings to obtain a possession order requiring you to vacate the bed at the Hospital.

The Trust does not wish to resort to legal action and therefore seeks your co-operation in discharge. The Trust does, however, remain concerned that your continued inpatient stay, which is not medically required, is having the effect of preventing access to care and treatment for other patients who do have current medical needs. Therefore, the Trust is prepared to issue Court Proceedings if you do not co-operate with your proposed discharge. **[the Trust should consider whether it would be appropriate, at this point, to give the patient a deadline by which to vacate the bed/co-operate with discharge arrangements, failing which Court proceedings will be issued]. Before requesting CEO signature, letter should be approved by either Chief Operating Officer/Chief Nurse/Chief Medical Officer**

You may wish to obtain independent legal advice in relation to this letter.

Yours sincerely

Hospital CEO

January 2023. Nottinghamshire County Council have been consulted in the development of this document and sign up to it as an NHS protocol that our staff in MDTs will support as partners.

HM Government

NHS

Looking after family or friends after they leave hospital?

This leaflet lists useful advice for family and friends of people needing ongoing care or support with day-to-day life.

What kind of support could you give someone

Support may be in the home or remotely (e.g. by phone), such as:

- **Emotional support** like helping someone manage anxiety or mental health;
- **Housework** like cooking, cleaning or other chores;
- **Personal support** like help moving around, washing, eating or getting dressed;
- **Assistance with getting essential items** like medicine or food; or
- **Help to manage money, paid care or other services**

If you are not able to care, and/or need help, then you have a right to a carer's assessment to have your needs considered too.
Check what your council or local authority can offer. Find their websites using the online postcode tool at www.gov.uk/find-local-council. Services may change during the pandemic.

What to consider if you are looking after someone

1. Get help from others with caring and everyday tasks:

- **Go to the Carers UK and Carers Trust websites** for information about support available. Carers UK also have an online forum where you can

speak to other carers, and a free helpline, open Monday to Friday, 9am to 6pm on **0808 808 7777**. Carers UK website:

www.carersuk.org/ *See over...*

- **If you are employed, talk to your employer** about managing work whilst caring. You may be able to arrange flexible working and many employers offer other support to make things easier.

- **If you are at school, college or university, let them know you are caring for someone** so they can help you manage your studies. Carers Trust has lots of helpful advice for young people looking after family members or friends. Carers Trust website: www.carers.org/

- **Get specialist advice about caring** from condition-related organisations like Alzheimer's Society, MIND and others. Also AgeUK:

  www.ageuk.org.uk/information-advice/care/arranging-care/homecare/

- **Try not to do everything yourself!** Speak to friends and family about what others can do to help. Can they share any tasks?

2. Look after your health as well as the person you support:

It is important to look after your own health and wellbeing. Eat a balanced diet, get enough sleep and try to make time each day for physical activity. Even taking a few breaths can relieve stress and help you manage each day. Check out the NHS 'Every Mind Matters' website for more tips: www.nhs.uk/oneyou/every-mind-matters/. If your own health or the health of the person you support gets worse, with coronavirus or another illness, talk to your GP or call NHS **111**.

3. Think ahead to make care manageable if things change:

Write down what care the person needs and what others should do if you cannot continue providing care for any reason. It is important that others can easily find your plan and quickly understand what needs to be done if you

aren’t there. Carers UK have advice on their website on how to make your plan.

4. Seek extra support from NHS Volunteer Responders:

Carers as well as those they care for can get a range of help including with shopping and other support by calling **0808 196 3646**.

Planning together: leaving the discharge to assess bed following your period of assessment.

Integrated Care System
Nottingham & Nottinghamshire

This leaflet explains why it is important to start planning your discharge from the discharge to assess bed.

Why are we starting to plan for me to leave hospital?

Our top priority is to help you get better and support you to be discharged to your long-term discharge destination after your assessment period. You will only be discharged once all assessments of your long-term needs have been completed and it is safe to do so. It is important that, together we start planning right away to ensure this is safe and in a timely manner.

In most cases, you will return home. However you may have been assessed for a long-term placement and you will have been involved in this decision.

What might I expect?

Early conversations - Soon after you arrive in the discharge to assess pathway we will discuss and plan how you will be able to leave. We will involve your carers, family and/or friends in conversations if you would like them to be included.

'Expected date of discharge' - Soon after you arrive you will be given an 'expected date of discharge', which will be reviewed during your stay.

What matters most to you to be considered - The team caring for you will ask 'what matters most to you?'. They will ensure this is considered when planning for you to leave hospital.

Questions to ask during your hospital stay:

1. What is the main reason I am here and what am I being assessed for?
2. What is going to happen to me today and tomorrow?
3. What extra help might I need when I leave here?
4. When will I be able to leave?

Integrated Care System
Nottingham & Nottinghamshire

Assessment completed: returning home.

This leaflet explains why you are leaving the discharge to assess bed

Why am I leaving?

The team caring for you have agreed that your long-term needs have been assessed and it is safe for you to return home to continue your recovery.

Why can't I stay here ?

All your long-term needs assessments have been completed and you are now able to return home. Staying here for longer than necessary may reduce your independence, result in you losing muscle strength or expose you to infection. No one has the right to remain here after their period of assessment has finished.

Our top priority is to ensure you are in the right place at the right time for the best recovery possible. The best place for you right now is at home where you can continue to recover in a familiar environment. However, in some circumstance we may not able to immediately provide the level of care you need at home. In these circumstances you will be asked to consider some options:

- Going to stay with a relative/carer until your care at home can be provided
- Going to an interim care bed until your care at home can be provided
- Going home without the care and support that has been recommended to you

What might I expect?

The team caring for you will discuss transport and other arrangements with you (and your carers, family and/or friends if you wish). If you have coronavirus you will be provided with advice about self-isolation requirements.

Integrated Care System
Nottingham & Nottinghamshire

Assessment completed: moving or returning to another place of care

This leaflet explains why you are leaving here and what you might expect after you have left.

Why am I leaving

The team caring for you have agreed that your long-term needs have been assessed and it is safe for you to move to another place of care.

Why can't I stay here?

Your long-term needs assessments have been completed and you are now able to return home to your usual place of residence or to another place of care. Staying here for longer than necessary may reduce your independence, result in you losing muscle strength or expose you to infection. No one has the right to remain here after their period of assessment has finished.

Our top priority is to ensure you are in the right place at the right time for the best recovery possible. The best place for you right now is your usual place of residence or to another place of care where you can continue to recover in a familiar environment. However, in some circumstance we may not be able to immediately provide the level of care you need at your usual place of residence. In these circumstances you will be asked to consider some options:

- Going to stay with a relative/carer until your care can be provided
- Going to an interim care bed until your care at your usual place of residence can be provided
- Going to your usual place of residence without the care and support that has been recommended to you.

Leaving here once your assessment has been completed is not only best for you but will free-up a bed for someone who is needing to be in a hospital setting due to being medically unwell. No one has the right to stay here once their assessment period is completed, while awaiting their preferred long term care option.

What might I expect?

The team caring for you will discuss transport and other arrangements with you (and your carers, family and/or friends if you wish). If you have coronavirus you will be cared for in a setting that is able to ensure you and everyone are kept safe.

APPENDIX 5 – NCTR FLOWCHART