

INFORMATION FOR PATIENTS/FAMILIES/CARERS

Discharge information

When patients are well enough to leave hospital, they will be discharged back to their usual place of residence if their care needs haven't changed since they came in.

However, some patients may go through significant changes to their health in hospital and might need extra help or support when they go back to their residence.

Patients do not have the right to remain in hospital once they are well enough to be discharged.

Sherwood Forest Hospitals NHS Foundation Trust follows a plan called 'Discharge to Assess' and a way of working called 'Home First, which focuses on helping patients go home as soon as it's safe.

Discharge to Assess (D2A)

This is about helping patients get better and learn to live on their own again. The help can be given in their homes or in a special community bed where staff can see what kind of care they will need in the future, once they have recovered as much as possible.

When patients are well enough to leave the hospital but still need some support, the hospital ward will contact a team called the Integrated Discharge Advisory Team (IDAT). Depending on how much help is needed, a special discharge nurse or a discharge coordinator will come to the ward. They will fill out a form called a Discharge to Assess (D2A). This form explains what support the patient needs.

After the D2A is filled in, it is sent to another team called the Transfer of Care Hub (ToCH). This team includes workers from many services, such as IDAT, Adult Social Care, Nottinghamshire Healthcare, START, Community First, Age UK, Home from Hospital, Bassetlaw Action Centre and Tu Vida.

The Transfer of Care Hub looks at all the referrals and, as a team, decides the best discharge pathway for each patient. The pathway they choose (pathway 1, 2, or 3) depends on what the patient needs based on the D2A assessment:

- **Pathway 1**

Patients who are well enough to go back to their own homes, but still need a bit of short-term help to get stronger and recover, can use this option. They will be matched with the right team or care worker who has space to support them. They will also be given a social worker who will check on them and help figure out what long-term support they might need while they're living at home.

- **Pathway 2**

Patients are transferred to a community bed-based setting to receive further rehabilitation, reablement or further assessment.

Patients on this pathway will be given a bed in the place that suits them best and has space available. This might be Mansfield Community Hospital or Newark Hospital if you live in Nottinghamshire, or Lings Bar if your GP is in South Nottinghamshire or Nottingham City.

- **Pathway 3**

Some patients have more serious health needs and need extra care for a longer time. These patients are moved to a place where they can stay while a special check, called a Decision Support Tool (DST), is done. This check can take up to 28 days and is used to decide if the NHS will pay for their long-term healthcare, known as NHS Continuing Healthcare funding.

If this pathway is chosen, a Pathway 3 navigator will help find the best nursing bed for the patient. This bed might not always be close to their home, because it depends on what kind of care the patient needs.

Out of area referral

If a patient lives in a different area, the D2A will be sent to the relevant Transfer of Care Hub (ToCH) for that area to look at. The ToCH does not help find short-term support or community beds for people who live outside the area.

Further sources of information

NHS Choices: www.nhs.uk/conditions

Our website: www.sfh-tr.nhs.uk

Patient Experience Team (PET)

PET is available to help with any of your compliments, concerns or complaints, and will ensure a prompt and efficient service.

King's Mill Hospital: 01623 672222

Newark Hospital: 01636 685692

Email: sfh-tr.PET@nhs.net

If you would like this information in an alternative format, for example large print or easy read, or if you need help with communicating with us, for example because you use British Sign Language, please let us know. You can call the Patient Experience Team on 01623 672222 or email sfh-tr.PET@nhs.net.

This document is intended for information purposes only and should not replace advice that your relevant health professional would give you. External websites may be referred to in specific cases. Any external websites are provided for your information and convenience. We cannot accept responsibility for the information found on them. If you require a full list of references (if relevant) for this leaflet, please email sfh-tr.patientinformation@nhs.net or telephone 01623 622515, extension 6927.

To be completed by the Communications office
Leaflet code: PIL202512-01-DISI
Created: December 2025 / Review Date: December 2027