Open Report on behalf of Glen Garrod, Executive Director - Adult Care and Community Wellbeing	
Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**05 April 2023**
Subject:	**Acute Hospitals – Admission to Discharge Care Pathway**

Summary:

This report explores the impacts arising from the discharge of patients from hospitals, focusing on the Active Recovery Beds and Pathway 1 Discharge to Assess initiatives, which were developed to improve patient flow in Lincolnshire's acute hospitals.

Actions Required:

To note progress, activity, and outcomes.

1. Background

A report, 'Lincolnshire Health and Social Care Patient Flow and Discharge Programme' was considered by the Health Scrutiny Committee for Lincolnshire on 14 December 2022, which set out the whole system improvement work taking place to improve patient flow and discharge by all system partners (Appendix A), summarised under three key areas:

(1) Build increased capacity in Pathway 1, delivered by health and social care, to offer patients reablement, rehabilitation and recovery in their own homes immediately after a hospital stay.
(2) Put in place an integrated discharge hub, (Transfer of Care Hub) at the interface of the acute and the rest of the system at the 'back door' to support continuous flow across the system.
(3) Improve the number of patients leaving the acute trust each day via Pathway 0 (no support required) and Pathway 1 (support provided in their own home).

In relation to Adult Social Care and Community Wellbeing Directorate (ASSCW), this report focuses on Pathway 1 Discharge to Assess, Pathway 1 Hospital Discharge Reablement Service and the Active Recovery Beds initiatives which were developed to improve patient flow in Lincolnshire's acute hospitals.

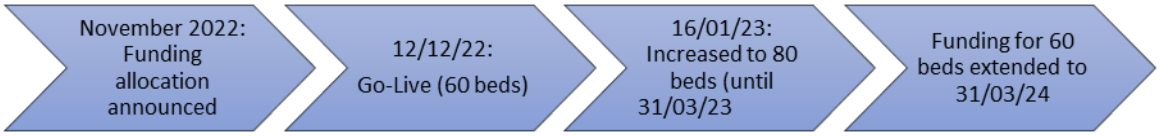
The Active Recovery Beds (ARB) service supports a person's transfer to the most appropriate setting and provides care led reablement that cannot be provided in a

person's own home for a short period of time. The level of reablement service provided to each person during their ARB stay is based on a comprehensive individual detailed care plan with input from the multi-disciplinary team (MDT) including the care provider, social work practitioner and health professionals.

The core principle of the service is to maximise an individual's independence and enable a person to resume living in their own home safely in a time-efficient manner. The ARB service is not intended for all hospital discharge but supports those requiring an integrated response to enable them to live at home independently with a reduced level of statutory services.

2. Active Recovery Beds

The Lincolnshire System Oversight Group agreed to support the ARB proposal for 60 ARBs across the county, which received funding from the Lincolnshire Integrated Care Board (LICB) and is commissioned and managed by LCC:



ARB Service aims:

- Improve outcomes for those who are medically fit and who, with a short period of intensive reablement in a bed-based setting, can return and remain in their own home safely, with a reduced package of care.
- Facilitate the timely discharge from acute care (e.g., from hospital for those who no longer require acute medical intervention) which should not be delayed by the requirement for a further period of assessment or an action to be taken to enable a return home.
- Improve outcomes for those who experience delays in discharge due to awaiting a community social care reablement service or a new homecare package. Ensuring that those people continue their recovery in a setting where reablement and support to return to a level of independence is the primary focus.
- Increase the prevention of unnecessary admissions (including readmissions) to hospital of people in crisis, who could safely be looked after elsewhere (e.g., in an Active Recovery Bed) and supported to be re-abled at home.
- Maximise Pathway 1 discharges from inpatient settings by increasing community capacity to support patients who, once medically optimised, require a short period of bed based reablement. The purpose of the reablement is to allow them to resume living at home safely in a time efficient manner and where possible with a reduced package of care.
- Reduce the length of hospital stays.
- Reduce the rate of readmission to acute settings.

Criteria:

- Adults who no longer require acute hospital care, and for people whose needs cannot be met at home and require a period of short-term support within a residential setting to assist with discharge or prevent unnecessary hospital admission are eligible for the service.
- In addition, those referred will:
    - be residents in Lincolnshire and registered with a Lincolnshire GP.
    - be eligible for services under the Care Act 2014.
    - if in hospital, have completed their episode of acute medical care, be medically optimised for discharge and have had a discharge action plan completed.
    - if in the community, be medically stable and avoid hospital admission.

Referrals are received from:

- Acute hospitals – primarily P1 (step down).
- Urgent Community Response (step up).
- EMAS (admission avoidance).
- GP's (admission avoidance).
- Adult Social Care - Community teams and out of hours (to avoid hospital admission and residential care placements).
- Admissions accepted 7 days a week 52 weeks a year from 7am to 10pm.

Activity as of 5 March 2023 was as follows:

- Number of referrals: 216.
- 85% of referrals accepted (184), of which 24 failed to start.
- 26 referrals not accepted.
- 24 accepted referrals failed to start.
- 3 people went over the 4 weeks (exceptional circumstances).
- Average length of stay in an ARB: 21.49 days.

Outcomes:

- 31% returned home with no ongoing LCC/health funded support (presumed that this is including those with self-funded home care?)
- 32% returned home with either an LCC funded home care package or home based reablement.
- 20% moved into alternative bed-based provision.
- 14% readmitted to hospital.

3. Pathway 1 Discharge to Assess

When deemed medically optimised, all customers are triaged through the multidisciplinary Transfer of Care Hub, with a view to offering rehabilitation and

reablement to customers in their own home, thus promoting a strengths-based approach which enables independent living. Once home, customers are assessed in their own home to identify actual need. ASCCW were instrumental in working alongside Lincolnshire Community Health Services in supporting discharges to customers home, utilising a hybrid model of both reablement and rehabilitation, which has reduced the need for long term support and freeing up services for others. As of 8 March 2023, 66 Lincolnshire residents were receiving a service at home.

This joined up approach has led to one assessment of need being completed, rather than several assessments being completed by different organisations to ensure identified outcomes are achieved.

4. Pathway 1 Hospital Discharge Reablement Service

At the beginning of December 2022, it became apparent that a number of customers were being admitted into hospital after long waits in Emergency Departments at both Lincoln County Hospital and Pilgrim Hospital Boston. Evidence shows that when customers, especially Older Adults are admitted into hospital, they can lose daily living skills and then potentially require packages of care to facilitate their discharge.

To address this concern, Lincolnshire Reablement Service introduced a new pilot in which the reablement team identified customers in ED and if able to leave hospital, met the customer at home upon discharge, providing an enhanced level of support for up to 48 hours. This service is particularly beneficial to older adults who may have fallen or sustained a minor fracture and lost confidence in returning home. Rather than being admitted into hospital or an alternate setting such as a Care Home, customers returned to their own home and any support required was provided by the reablement team.

As of 14th March, of the 54 customers had accessed the reablement service in this way, 34 did not require an ongoing service. A further 20 went on to receive ongoing reablement after the initial 48 hours.

One customer advised that she had fallen and broken her wrist. She was anxious about returning home and initially consideration was given that she may need to be admitted into hospital. The customer returned home with the hospital discharge reablement service who arranged equipment and actively promoted recovery through confidence building and support at the right time, in the customers own home. The customer is now living independently at home without support.

5. Conclusion

The Active Recovery Beds and Pathway 1 initiatives are offering residents of Lincolnshire the opportunities to recover and regain independent living skills. For those that do not become fully independent, the support packages they require are significantly reduced, freeing up services for others, which supports timely discharges from the acute hospital sites. All of these discharge pathways are effective, efficient and value for money.

6. Consultation

a) Risks and Impact Analysis

N/A

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Lincolnshire Health and Social Patient Flow and Discharge Programme report to the Health Scrutiny Committee for Lincolnshire on 14 December 2022

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

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