

Intermediate Care



Leicester
City Council



Leicestershire Partnership
NHS Trust

healthwatch

Leicester and
Leicestershire

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Intermediate Care

- Intermediate Care is health funded support to prevent admission to acute care or to support discharge where there are some on-going needs, but an immediate medical episode is resolved
 - Can be provided in a person's own home – reablement- or in residential care settings
 - The aim is to gain or regain skills for living as independently and safely as possible
 - The role of adult social care is to support discharges where people no longer require acute care but are not yet ready to return home – known as Pathway 2.
 - Discharge support may be needed from Leicestershire Partnership Trust wards (Ward 4, Coalville/Charnwood Ward, Loughborough/ Beechwood and Clarendon Wards)
 - We also arrange discharges into residential care directly from UHL care using a shared funding agreement with the Integrated Care Board.
 - This currently means a person's stay is funded 100% by Health for the first week and on a 50/50 split between ICB and ACS for weeks 2-4
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Community Hospitals

Total 259 beds across 13 wards and 7 hospital sites

- 9 CHS Core Wards providing step down / step up care where anticipated outcome for discharge is via P0 / P1 / P3 pathways
- 2 Stroke Wards for step down stroke rehab
- 2 wards supporting step down D2A pathway
Patients who would benefit from RRR approach before going home or into long-term placement

Workforce

- Nursing and Allied Health Professionals Cover
- Medical Cover



E Efficient and effective



Coalville Community Hospital



Evington Centre



**Loughborough
Community Hospital**

Community Hospital Ward Therapy Offer

Staffing

- Registered Physiotherapy and Occupational Therapy cover on all wards
- Therapy support workers and Assistant Practitioners on all wards to support registered staff and patients
- Meaningful Activity Co-Ordinator (MAC) support – 1:1 and groups

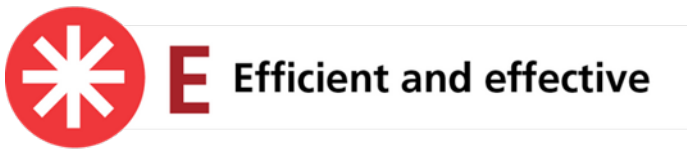
Activity

- All wards therapy teams deliver personalised intervention to patients who will each have individualised goals and plans. The objective is to support patients to rehabilitate to a level where they are safe to go home (if appropriate) and continue their recovery journey.
- All wards offer individual therapy and group therapy offers e.g. Breakfast clubs, exercise groups, coffee and chat, activity groups working on function.

Data monitoring

- Reporting on Patient Independence Outcome Measure – this captures any changes in levels of independence in appropriate patients. Majority of patients show an improvement in level of independence during their inpatient stay.
 - Use of clinical data from SystmOne is being scoped to capture activity detail, demand and capacity
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Outcomes



Av. LOS
Beechwood &
Clarendon
20 – 23 days
Ward 4 & Charnwood
25 days

Discharges – Aug
2026 (CoHo)
32% - P0
58% - P1
2%- P2
8% - P3

PIOM Scores
Average of 60% pts
show
improvement

F&FT Scores
75% - 100%

D2A Pathways - All patients had 24hr care needs and were unable to return home from the acute setting with Pathway 1 support (discharged home with a new or increased package of care)

Charnwood Ward

City	Jan 2026	Feb	March	April	May	June	July
Pathway 1	2		3	1	2		5
Pathway 3							2

Ward 4 Coalville Hospital

City	Jan 2026	Feb	March	April	May	June	July
Pathway 1	1	2	5		2	2	1
Pathway 3			2	1	1	5	1

Intermediate Care



- Our current database does not support tracking outcomes for people who have been discharged with intermediate care support
- We have data about people who have returned home with care and their levels of independence after 90 days – this is a national ASC performance measure (Leicester is currently achieving 92%)
- We can identify people who were discharged into residential care using the shared funding scheme
- We cannot use our reporting systems to distinguish discharge support from an LPT ward or an acute UHL ward
- We have done a manual trawl to track some of these discharges, but the data is not wholly complete or reliable

Intermediate Care



- The demand for support for people on Pathway 2 is rising
- The outcomes for people differed according to where they received their intermediate care

A manual data trawl has shown that;

- 30% of people discharged via ASC from Preston Lodge return home
- 30% of people discharged via ASC from Preston Lodge move into permanent residential care
- 19% of people known to ASC at Preston Lodge are readmitted to acute care
- Other outcomes include; people being readmitted to acute care, people dying, people whose care becomes 100% health funded, people who need a further period of short term residential care

Enter & View Discharge Wards

In October to December 2025, Healthwatch visited Beechwood & Clarendon wards (Evington Centre), Thringston ward (Coalville Community Hospital) and Charnwood ward (Loughborough Hospital).

The purpose of the visits was to understand people's experience of community hospital discharge wards and observe the ward environments and accessibility.

Overview of findings

- The experience of patients across all four wards was consistently positive.
 - Wards were observed to be calm, welcoming, clean and well-maintained.
 - Discharge planning starts on admission, supported by strong multidisciplinary working.
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Healthwatch Leicester and Leicestershire gathered feedback from **119 patients and carers** on their recent hospital discharge experiences to assess progress since 2020 and identify remaining gaps in care.

Key findings

- 58% of respondents felt involved in discussions about their discharge.
 - 38% said they did not receive clear information about follow-up care, medication or support after leaving hospital.
 - 71% received a copy of their discharge summary, though some reported inaccuracies.
 - 60% were discharged within the timeframe they expected; medication delays were the most common cause of frustration.
 - Only 16% of carers were informed of their right to a Carers' Assessment.
 - Three-quarters (76%) of respondents felt ready to go home, though some described feeling unsupported once home.
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Emerging themes

- These themes emerged from both the survey responses and written comments provided by respondents.
 - **Communication gaps:** Patients and carers often felt uninformed about discharge timings, medication or follow-up arrangements.
 - **Medication delays:** Waiting for prescriptions remains a key cause of discharge frustration.
 - **Carer inclusion:** Carers frequently felt excluded from discussions and unaware of available support.
 - **Aftercare coordination:** Some respondents described confusion about community support and ongoing treatment.
 - **Positive staff experiences:** Many praised the compassion and professionalism of staff during their stay.
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- **What patients and carers want to see improve**
 - Clear, timely communication about discharge timing, medication and aftercare
 - Faster pharmacy processes to avoid unnecessary delays
 - Proper recognition and involvement of carers in planning
 - Confirmed support and equipment in place before leaving hospital
 - Follow-up contact shortly after discharge to prevent problems escalating
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What is working well

Patient satisfaction: Surveyed patients reported being 'happy' or 'very happy' with their care.

Effective discharge coordination: Dedicated discharge teams and coordinators are improving flow and reducing delays.

Good communication: Patients are usually kept informed about discharge plans.

Accessibility: Clear signage, wide corridors, accessible toilets and availability of wheelchairs across most wards.

Wellbeing and independence: Access to therapy spaces, meaningful activities, gardens and encouragement to regain independence.

Strong staff teamwork: Collaborative working between ward staff, therapists, discharge teams and social care.



Key issues identified

Accessibility: Some en-suite bathrooms on Clarendon Ward are small and less accessible.

Wheelchair availability: Demand may exceed supply at Thringston Ward.

Patient information: Alternative formats (easy-read, large print, braille) are available but not always clearly signposted.

Transport delays: Non-emergency transport waiting times can cause frustration, with communication not always clear.

Choice and understanding: Some patients felt limited choice around discharge destination due to system pressures.

Recommendations

There are eight recommendations in the report for Leicestershire Partnership NHS Trust (LPT) and system partners which include:

1. Use the findings to inform ongoing discharge and flow improvement.
 2. Improve en-suite bathrooms on Clarendon Ward.
 3. Increase meal choice and cultural options.
 4. Ensure enough wheelchairs are available at Thringston Ward.
 5. Strengthen patient involvement and choice.
 6. Increase visibility of accessible information.
 7. Improve communication about hospital transport.
 8. Share good practice across wards.
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