REPORT OF: THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC):

Support for People Leaving Hospital

Report by: Dr Omid Nouri, Health Scrutiny Officer, Oxfordshire County Council

Report to: Karen Fuller (Director Adult Social Care)
Hannah Berry (Home First System Lead)
Sally Steele (Head of Service – Hospitals)
Tamsin Cater (Head of Transfer of Care Hub)
(As representative of the Health and Social Care System)

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report by the Director for Adult Social Care on the support being provided for people who leave hospital.

2. The Committee would like to thank Matthew Tait (BOB ICB Chief Delivery Officer); Hannah Berry (Home First System Lead); Sally Steele (Head of Service – Hospitals); Tamsin Cater (Head of Transfer of Care (TOC) Hub); and Karen Fuller (Director Adult Social Care, Oxfordshire County Council) for attending the meeting item on the support for patients discharged from hospital on 30 January 2025 and for answering questions from the Committee in relation to this.

3. The Committee received a report on this item 12 months ago on 16 January 2024, and was keen to receive an update on the collective work by system partners around the Discharge-to-Assess (D2A) process and on the extent to which patients leaving hospital are provided with as adequate support as possible when returning home.

4. This item was scrutinised by HOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the support that patients could expect to receive after leaving hospital. When commissioning the report for this item, some of the insights that the Committee sought to receive were as follows:

    - An overall update on the current state of affairs around D2A and in providing support for people leaving hospital (including support in people's homes).

    - An update on any progress made on implementing the HOSC recommendations issued to system partners when this item last came to the Committee in January 2024.

- How system partners perceive the outcome of the recent Healthwatch Oxfordshire project on discharged patients, and any actions being taken to address the recommendations issued by Healthwatch Oxfordshire around supporting people who leave hospital.
- Details of any challenges system partners may be facing around providing support to discharged patients.

SUMMARY

5. During the meeting on 30 January, the Director of Adult Social Care emphasised the collaborative approach and ongoing improvements in performance and reablement outcomes. They also mentioned the positive work undertaken in partnership with Healthwatch.

6. It was explained to the Committee that since January 2024, Oxfordshire's Home First Discharge to Assess (D2A) service had significantly improved hospital discharge performance, reducing the average length of stay and increasing patient support. Despite higher demand and funding challenges, many patients were gaining independence through reablement pathways, with more referrals from community settings.

7. A key aspect of the discussion revolved around the suitability of a discharged patient's home environment. It was conveyed to the Committee that during the 72-hour assessment delay, known home environment issues were discussed prior to discharge, and a care provider assessed the home on the day of discharge to flag any rehabilitation challenges.

8. The Committee sought information on the equality of the rollout of services across Oxfordshire, focusing on staffing levels in urban and rural areas. It was explained that the rollout had been planned using demand and capacity modelling, which considered the geography and specific needs of different areas

9. Another aspect discussed was the sustainability of funding for additional discharge services given the financial pressures, and how the system planned to manage this in the future. The Director of Adult Social Care and the Commissioning Manager explained that the success of the discharge services had increased the need for more funding in community services. They were discussing fund allocation within the system to support these services and were utilising the Better Care Fund (BCF) planning process to align different funding streams to maximise resources.

10. Steps were discussed to investigate and understand the causes behind hospital readmissions and the measures implemented to reduce this. The Director of Adult Social Care and the Head of Service explained that reducing readmissions was a priority, focusing on providing comprehensive care for individuals with long-term conditions to prevent acute flare-ups and hospital readmissions. They utilised integrated neighbourhood teams and primary care resources to understand individual needs and baselines

KEY POINTS OF OBSERVATION & RECOMMENDATIONS:

11. This section highlights 2 key observations and points that the Committee has in relation to supporting people discharged from hospital. These 2 key points of observation have been used to determine the recommendations being made by the Committee which are outlined below:

Data sharing to determine causes of non-elective admissions: The Committee is pleased to hear that reducing readmissions was a priority for system partners in Oxfordshire. Indeed, the focus should be on delivering all-rounded and personalised care for patients suffering with long-term conditions. This would help avert the likelihood of patients being abruptly or frequently readmitted to hospital. The Oxfordshire Way emphasises prioritising care in people's homes, and support in people's homes can only be safe, effective, and sustainable if patients are supported in ways that prevent them from developing abrupt flare ups in their condition.

The ability to share data effectively across the system is crucial in understanding the causes of non-elective hospital admissions. Non-elective admissions, often sudden and unplanned, can be challenging to manage and predict. By enhancing data sharing practices and building strong relationships amongst system partners, the system can offer better care and possibly reduce the frequency of these admissions. According to a 2016 study published in the *Medical Research Methodology Journal,* it was found that on an individual patient-level, understanding the causes of non-elective admissions and preventing these involved the need to share data across all relevant health and care providers that a patient would have been in contact with, only then will a comprehensive all-rounded understanding of a patient's condition and health tendencies be achieved[1].

Moreover, on a broader structural-level, data sharing between Oxfordshire's system partners would enable health and care professionals to analyse patterns and identify potential causes of non-elective admissions amongst the County's population. This data can include medical histories, demographic information, and previous hospital visits, which can be aggregated and examined to uncover trends and risk factors.

Some of the benefits of data sharing amongst system partners include:

- Improved Patient Care: Access to complete patient data helps doctors and nurses make informed decisions quickly, enhancing the quality of care.

[1] Comparison of predictive modeling approaches for 30-day all-cause non-elective readmission risk | BMC Medical Research Methodology

- Predictive Analytics: By examining shared data, healthcare professionals can identify patients at risk of non-elective admissions and take preventative measures.

- Efficient Resource Management: Understanding the causes of non-elective admissions can help the NHS and the County Council to allocate resources more effectively, ensuring patients receive the care they need without undue delays.

Therefore, strong relationships and collaboration across the healthcare system are essential for successful data sharing, which would have a knock-on effect not only in reducing non-elective admissions but also in improving patient outcomes overall. The role of prevention is also important in this regard, and can help to reduce health inequalities by supporting those patients and residents who are the most vulnerable.

In terms of the practicalities of how data sharing could be maximised amongst system partners, there are two ways to achieve this. Firstly, system partners should hold regular meetings to discuss data sharing practices and challenges to help foster a collaborative environment and stronger understandings of trends in non-elective admissions. Secondly, system partners should identify common goals and objectives related to patient care and data sharing. This could further unify efforts and encourage cooperation.

Recommendation 1: *To support data sharing across the whole system to help to understand the causes of non-elective admissions into hospital. It is recommended that there is good relationship building across the system to support this.*

Funding/resources for Integrated Neighbourhood Teams: The Committee previously examined the role of Integrated Neighbourhood Teams (INTs) in previous HOSC public meetings, and remains supportive of the role of these teams. These teams can provide a strong network support base for patients who are discharged from hospital. INTs are vital components in the delivery of effective community-based health care. A key benefit of INTs lies in the presence of multidisciplinary professionals working collaboratively to provide holistic care to local communities. According to a 2025 study by the *Health Equity Evidence Centre*, Health inequalities are forecasted to increase over the next two decades and for people living in the poorest areas of the country, and that INTs are at the forefront of initiating work to tackle inequalities on a local level by providing integrated and multidisciplinary care for residents in their communities[2].

INTs should aim to provide seamless care by integrating services that address the physical, mental, and social well-being of residents throughout Oxfordshire, and particularly in rural localities where residents may experience difficulties accessing services or where health

[2] Integrated-neighbourhood-teams.pdf

personnel and infrastructure do not have a particularly heavy presence relative to urban areas. These teams should include general practitioners, nurses, social workers, mental health professionals, and other specialists who can collaborate to offer comprehensive care plans tailored to the individual needs of discharged patients throughout Oxfordshire. By working in neighbourhoods, these teams should ensure that care is accessible and responsive, reducing the strain on hospital services and promoting preventive health measures also.

For INTs to function effectively and for their potential to be maximised, sufficient funding and resources are paramount. Proper funding is crucial for the sustainability and effectiveness of INTs. Adequate financial support could enable these teams to:

- Recruit and retain skilled professionals.
- Invest in necessary equipment.
- Provide ongoing training and development for staff.
- Facilitate communication and coordination between different services.
- Expand services to meet growing demand for healthcare services and community needs.

Ensuring such teams are sufficiently resourced would involve the need to assess the demand for services that provide support for patients discharged from hospital. This would form a crucial part of the system being able to assess the degree to which individual neighbourhood teams should be resourced. System partners should also work toward securing additional local or national funding for such teams if necessary.

Ensuring the availability of a skilled workforce is crucial for maximizing support for discharged patients in both urban and rural areas across Oxfordshire. The Committee is calling for a thorough assessment of the current workforce for supporting discharged patients. This is essential to identify gaps and areas requiring immediate attention where they may be shortages of professionals. Therefore, system partners should evaluate the number of healthcare professionals, their distribution, and the services they provide.

In urban areas (including Oxford City), the focus should be on ensuring there are adequate numbers of healthcare professionals to cater to the higher population density and diverse patient needs. In rural areas, as one 2020 study in the *International Journal of Environmental Research and Public Health* outlines, the aim should be to address the challenges of geographical dispersion and limited resources, ensuring that patients receive consistent and high-quality care[3].

[3] The Whole-of-Person Retention Improvement Framework: A Guide for Addressing Health Workforce Challenges in the Rural Context

Recommendation 2: *To continue to support sufficient funding and resource for integrated neighbourhood teams. It is recommended that measures are taken to ensure workforce availability to maximise support for discharged patients in both urban and rural areas across Oxfordshire.*

Legal Implications

12. Health Scrutiny powers set out in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide:
 Power to scrutinise health bodies and authorities in the local area
 Power to require members or officers of local health bodies to provide information and to attend health scrutiny meetings to answer questions
 Duty of NHS to consult scrutiny on major service changes and provide feedback on consultations.

13. Under s. 22 (1) Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 'A local authority may make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised'.

14. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

15. The recommendations outlined in this report were agreed by the following members of the Committee:

Councillor Jane Hanna OBE – in the Chair
District Councillor Katharine Keats-Rohan (Deputy Chair)
Councillor Yvonne Constance OBE
Councillor Jenny Hannaby
Councillor Michael O'Connor
Councillor Freddie van Mierlo
Councillor Mark Lygo
District Councillor Paul Barrow
District Councillor Elizabeth Poskitt
District Councillor Susanna Pressel
District Councillor Dorothy Walker

Annex 1 – Scrutiny Response Pro Forma

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