HOSC Briefing 16 January 2024

Supporting People to Leave Hospital: the Oxfordshire Way

Executive Summary

1. National Policy requires that Oxfordshire ensures that 95% of people who have been admitted to an acute in-patient bed return directly home to their usual place of residence after their hospital stay.

2. The policy also requires that people are assessed in their usual place of residence or outside the acute hospital setting.

3. This approach is better for patients as it reduces length of stay and the risks associated with that. It also works to improve hospital flow and so improves the safety and responsiveness of our emergency care pathways.

4. Oxfordshire's performance against the national policy target is monitored through the Better Care Fund Plan. In 2023-24 the Health & Wellbeing Board agreed that we should aim to improve our performance to 93% of people discharged to usual place of residence by March 2024 and improvement to the national requirement of 95% during 2024-25. Currently and historically we have not met the Better Care Fund plan targets, and this will require an effort to divert people from bed-based to home based discharge pathways.

5. Oxfordshire has reorganised its approach to hospital discharge to deliver on this improved care for patients and system performance. After a successful pilot, we are now rolling out a Home First Discharge to Assess approach to hospital discharge.

6. The changes we are making to the discharge pathways to deliver improved outcomes for patients and deliver system flow are underpinned by increased capacity in our domiciliary care market and changes in structure and approach of hospital-based teams.

7. A focus on getting people home will include a diversion from bed-based discharge pathways to home-based discharge pathways. That reduces the demand for short stay hub beds and may lead to a redesign of the model to meet specific patient needs.

8. The Oxfordshire Short Stay Hub bed model was developed out of the pressures on the acute hospital system in the winter of 2015-16 when Oxfordshire had some of the highest numbers of delayed transfers of care in the country. This was a temporary arrangement at the time. These were in turn driven by a lack of capacity in the local reablement and domiciliary care market.

9. The Oxfordshire Urgent and Emergency Care Board agreed to reduce the reliance on bed-based discharge pathways, and this was incorporated in the Better Care Fund plan for 2023-25. These changes will be kept under review and will need further operational changes from time to time to assure that we have the right resources in the right places and respond to changing patterns of demand.

10. A move from a bed-based to a home-based discharge pathway is safer for patients, delivers better outcomes and will be more economically effective over time. Our outcomes from reablement have improved significantly over the past two years. Currently 91% of people complete reablement with reduced care needs or fully independent (78% achieving full independence).

11. The changes are not risk-free but the whole approach is based on positive risk taking to support better outcomes for the individual and the system. We are developing community- based resources that support more preventative approaches to help people at risk of going into hospital. This approach is underpinned by and consistent with the Oxfordshire Way, our approach to enabling people to remain and thrive in their own homes and within their own communities. Strengthening our Discharge to Assess pathway is a vital contribution to this ambition.

National Hospital Discharge Policy: return to usual place of residence via *Discharge to Assess*

12. In August 2020 NHS England introduced a revised national Hospital Discharge Policy focussed on getting people home Hospital discharge and community support guidance - GOV.UK (www.gov.uk)

    a. Under the Discharge to assess, home first approach to hospital discharge, the vast majority of people are expected to go home (to their usual place of residence) following discharge. The 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, with timely and appropriate recovery support if needed.

    b. This approach reduces exposure to risks such as hospital-acquired infections, falls and loss of physical and cognitive function by reducing time in hospital, and enables people to regain or achieve maximum independence as soon as possible. It also supports hospital flow, maximising the availability of hospital beds for people requiring this level of inpatient care and elective surgery, such as hip replacements.

13. The Policy requires local health and care systems to move to *Discharge to Assess* approach. In the ADASS guidance Quick Guide: Discharge to Assess (www.nhs.uk) the risk of assessing people in hospital is characterised as

    a. Imagine leaving your home abruptly and never returning to it again.

    b. Imagine being told that you are moving house tomorrow and you have no control over where you are moving to and how much it will cost.

    c. This is what happens to people every day because we assess people in a place that is not their normal environment.

14. The national policy is built upon key principles:

    a. To support the ability of hospitals to maintain flow and be able to respond effectively to patients needing emergency assessment and treatment, patients should be discharged as soon as they no longer require an acute hospital bed.
    b. Discharging people as soon as they no longer require an acute hospital bed reduces the risks to the patient arising from an extended length of in-patient stay.
    c. People cannot be appropriately assessed for their longer-term needs from an acute hospital bed and need to be discharged prior to that assessment taking place.

d. In the majority of cases, that assessment should take place in the person's own home and take into account their individual circumstances in their own community.

15. The national policy specifies the discharge pathways to be used and the numbers of people who should be discharged against each one:

Pathway	Pathway 0	Pathway 1	Pathway 2	Pathway 2	Pathway 3
Definition	Home with no support	Home with support (reablement or assessment)	Bed-based reablement	Bed-based rehabilitation (high medical needs)	Long-term care (residential)
% of patient discharges	50%	45%	4%		1%
How delivered in Oxfordshire	*Self-discharged* *In some cases- with support from Age UK*	*Home First Discharge to Assess working with Live Well at Home framework providers*	*Short stay hub beds*	*Oxford Health community hospital beds*	*D2A beds (either in short stay hub beds or spot purchased)*

Better Care Fund Plan

16. The Better Care Fund Plan is required to deliver the Hospital Discharge Policy requirement that 95% of patients discharged from hospital go home, with or without support. Oxfordshire has not yet managed to meet this target. In the Better Care Fund Plan for 2023/25 the Oxfordshire Health & Wellbeing Board agreed a trajectory for 2023/24 that we would achieve 93% by March 2024 and 95% in 2024/25.

17. See Agenda for Oxfordshire Health & Wellbeing Board on Thursday, 29 June 2023, 2.00 pm - Oxfordshire County Council

18. Performance against planned trajectory to 30 Sep 2023

	22-23 Q1 Actual	22-23 Q2 Actual	22-23 Q3 Actual	22-23 Q4 Actual	23-24 Q1 Actual	23-24 Q2 Actual
Actual	90.6%	91.1%	90.3%	90.1%	90.8%	91.3%
Plan					91.0%	92.0%
Variation v plan					-0.2%	-0.7%
England performance	92.6%	92.9%	92.7%	92.3%	92.8%	*93.2%*

19. In 2023/24 we have seen an improvement in performance but currently Oxfordshire remains behind our planned trajectory. The changes set out below have largely reduced delays for patients waiting on Pathway 1 to go home. To achieve the trajectory, we need to divert people from Pathway 2 and 3 to Pathway 1 wherever possible in line with the

Discharge to Assess approach so a change of approach moving away from reliance on beds is required.

2023-24	All Discharges	3,891	4,233	4,387	4,160	4,384	4,407
	Usual Residence	3,499	3,871	3,996	3,787	3,998	4,036
	Other outcome	392	362	391	373	386	371
	Usual Residence %	89.9%	91.4%	91.1%	91.0%	91.2%	91.6%
	Other Outcome %	10.1%	8.6%	8.9%	9.0%	8.8%	8.4%

20. To move from 91.6% to our agreed trajectory of 93% of people going home we need to reduce the current 370-380 discharges per month to beds to 308 per month. This amounts to a reduction of around 15 discharges to a bed per week. That level of diversion will need to increase in 2024/25 to around 20 discharges per week to achieve the 95% target.

Reorganising Hospital Discharge Pathways: moving towards *Discharge to Assess*

Transfer of Care Hub

21. In November 2022 the Oxfordshire health and care system instigated a Transfer of Care [TOC] Hub in the hospital. Led by a matron in Oxford University Hospitals NHS FT with system partners, the TOC Hub works to allocate patients to the right discharge pathway, anticipate and pre-empt any barriers to discharge and promote a discharge to assess approach.

22. Since August 2023 the TOC Hub has also been coordinating all Oxfordshire discharges from the Royal Berks Hospital.

23. The TOC Hub has taken responsibility for allocating the right patient to the right pathway. This has clarified the needs of patients and how we use our discharge pathways. It has, for instance, removed the risk that a patient who needs bed-based reablement (recovery of day to day living skills) ends up in a rehabilitation bed (medically supervised recovery of health function) because there is a vacant community hospital bed but no immediate short stay hub bed capacity. We can have more confidence now in the "pathway prescription" for people awaiting discharge from hospital and use that in planning resources.

Home First Discharge to Assess

24. Prior to June 2023 Oxfordshire operated a two-track approach to discharging people home: *Home First* for those people identified as having reablement potential; and a bed-based assessment/home care sourcing approach to those identified as having long-term care needs. For the latter group this often led to a delay in beds whilst long-term care was sourced.

25. Oxfordshire now has a model that is aligned to the national Home First Discharge to Assess approach. This has been introduced on a staged approach in the City (June), North (August) and County wide (November).

    a. Where a patient can go home (whether for assessment, reablement, or long-term care) they are allocated to a provider from the Council's Live Well at Home Framework to support at home in daily calls 7 days a week.

b. The patient is discharged with the appropriate medication, equipment, and support.
c. The resident is then supported in her own home for up to 72 hours during which time their needs are assessed by the Live Well at Home provider and the Council Home First team.
d. At 72 hours (or earlier if indicated) they will proceed to reablement, to long-term care, or discharged if they can manage independently. The reablement and the long-term care will usually be delivered by the same agency for continuity.
e. If they are assessed by the Council as needing long-term care after the period of reablement, that is provided by the same agency in line with our Live Well at Home contract model, thus ensuring continuity of care.

26. To support more complex home first discharges the Council has introduced in agreement with Live Well at Home providers:
    a. Short-term live-in reablement care and/or
    b. Short-term waking nights to support reablement.
    c. These measures assure the safety of the initial assessment and reablement periods and help the resident and her family/unpaid carers have confidence in this approach.

27. In addition, the Integrated Care Board is leading on the development of Integrated Neighbourhood Teams. Working with primary care, these teams create wrap around short-term interventions for people who are at risk of hospital admission and/or for people who have been discharged from hospital where there are ongoing medical needs. There are teams in Bicester and Oxford City based around specific practices or Primary Care Networks, and this model is being rolled out in Witney, Banbury, Wantage and eventually across the County. These services build out from what is already there and so there are different models based on specific local resources, but all have the capability to support more vulnerable people in their own home.

Impact of Home First Discharge to Assess

28. In the City, where the pilot has been running longest, we have supported 87 people home who would otherwise have been waiting for a long-term social care package in a bed.

    a. We had D2A capacity in 88% of cases.
    b. Where we assessed at home this was completed within 72h in 87% of cases
    c. Where we have completed assessments
        i. 24% were fully independent at 72h.
        ii. 32% were for reablement at 72h.
        iii. 33% were for long-term care.

29. This suggests that only 33% of people waiting in a bed had a long-term care need.

30. Where people proceed to reablement, our providers achieve full independence in 78% of cases and reduce the initial care package in a further 13% of cases.

31. Taken together, these approaches demonstrate the case made out in the national Hospital Discharge Policy: when we get people home; and when we assess people at home, we can put in the support that enables the overwhelming majority of people to retain full independence.

Assurance for Home First Discharge to Assess

32. This approach is new for Oxfordshire, but we are building an infrastructure that will assure its continued positive impact:

33. Crucial to the flow through any home-based discharge model is the capacity of domiciliary care when it is needed so that we can continue to take people home from hospital. There are now over 100 providers on the Live Well at Home Framework, and we have seen a significant increase in the hours of care purchased:

Home care hours 01/12/2022	27,888
Home care hours 01/03/2023	28,885
Increase in 22/23	3.58%
Current hrs (1/11/23)	31,095
Increase in 23/24	**7.65%**

34. Live Well at Home Framework providers have responded to the Discharge to Assess opportunity in terms of undertaking training, ensuring capacity and joining daily case allocation meetings 7 days a week. We have made changes to the contract that reimburses providers in the delivery of the 72-hour Discharge to Assess support in cases where the person does not proceed to reablement or long-term care.

35. As noted above we have commissioned additional live-in and waking nights capacity to support more complex discharges.

36. The developing Integrated Neighbourhood Teams will be able to provide further support in more complex cases.

37. The Council has reorganised hospital teams to align to the model of taking people home rather than assessing them on the wards. The Council also commissions Age UK to support patients in the discharge pathway to give an independent view of what is needed and what is planned for the patient and their family. In 2024/25 we plan to extend that to a specific process to identify and support unpaid carers in the discharge pathways.

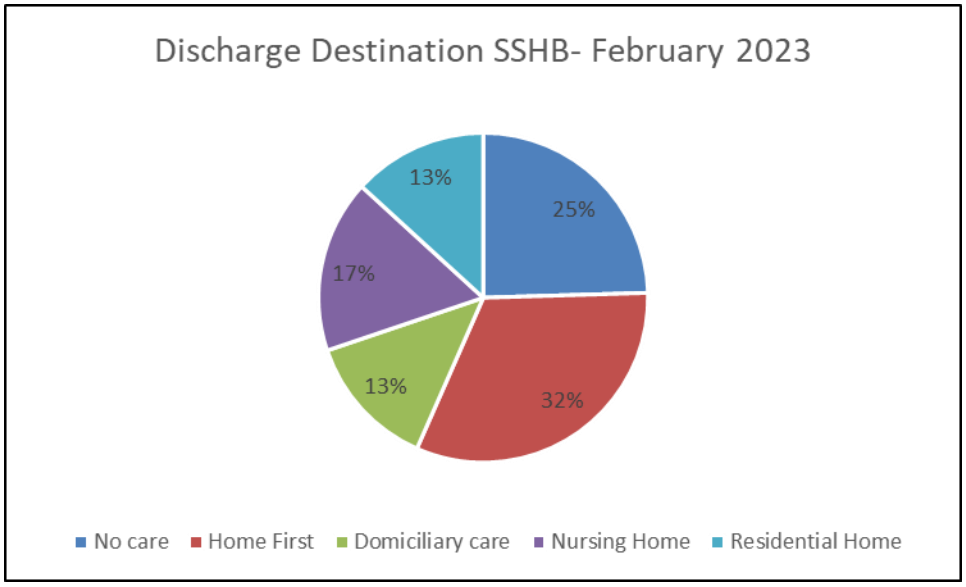
38. There is strong system wide leadership and support with a System wide Director of Urgent Care, TOC Hub Matron and Home First Lead hosted respectively by the Integrated Care Board, Oxford University Hospitals NHS FT, and the County Council. Progress and lessons learned and opportunities to develop the model and address any concerns are monitored in fortnightly system-wide Urgent Care Delivery Group meetings reporting monthly to the Urgent and Emergency Care Board.

Impact of Home First Discharge to Assess on other discharge pathways

39. As set out at paragraph 15 and 20 the assumption in the national Hospital Discharge Policy is that we will divert more people home for assessment and onward care. In Oxfordshire there are several benefits to this:

    a. Fewer people will need to be placed in a bed on their journey home from hospital as we move to divert the 15-20 people per week who should be going home rather than to a step-down bed. Given the numbers that end up going home (see below) the opportunity to go “home first” is significant. The TOC Hub and Home First teams are now working with Live Well at Home providers to move people who need reablement to a home first pathway wherever appropriate.

b. Where people go into short stay hub bed the focus on "home first" from that setting will support a reduction in length of stay.
c. In most cases (over 70%) people who go to a short stay hub bed are discharged home. The increased capacity set out above will support that flow and reduce the risk of delays in step down beds, reducing length of stay in both settings.



40. Based on assumptions around a reduced demand for short stay hub beds arising from the diversion to home-based discharge, and the reduced length of stay, the Urgent and Emergency Care Board agreed in May 2023 to request the Council to reduce the contracted short stay hub beds to 63 for winter 2023-24, and plan to reduce further to 40-45 from April 2024.

41. Since that decision and the implementation of Home First Discharge to Assess there is assurance that the trajectory is correct in terms of bed numbers. There is a line of enquiry that suggests that we may need to rethink the specific short stay hub bed model based on specific needs relating to dementia care and/or to delirium presentations. The model of care will be reviewed by the Urgent Care Delivery Group as part of the refresh of the Better Care Fund plan for April 2024.

The Oxfordshire Short Stay Hub Bed Model

42. Oxfordshire historically faced significant challenges in achieving flow out of acute hospital beds. In the period to 2015/16 Oxfordshire was generally one of the worst performing systems in terms of *delayed transfers of care* with many people remaining in a hospital bed longer that was necessary with the risk of longer-term harm to their welfare.

43. In 2015/16 Oxford University Hospital NHS FT began purchasing "liaison hub beds" in care homes to support flow out of the hospital at times of pressure. The hospital had purchased 130 beds by March 2016 but reduced to 55 by August. The beds were supported by a Liaison Hub managed by the hospital and funded by the then Clinical Commissioning Group. The Hub comprised nurses, therapists (from both the hospital and from Oxford Health NHS FT) and social workers from the Council. The model was a mixture of therapy-led reablement designed to get people home from the hub bed and assessment where people may have long term care needs (eg people needing a Continuing Healthcare assessment).

44. The number of people delayed in hospital reduced from 140-150 in Nov 2015 to 95 by August 2016. It was agreed that the "liaison hub bed model" should continue in Sep 2016.

45. In parallel to the liaison hub beds the Council commissioned 34 intermediate care beds from the Order of St John Care Trust which had a similar function, to support reablement and lower levels of rehabilitation. These numbers were increased in Dec 2016 when the Council was asked by the Clinical Commissioning Group to commission 7 additional step-down beds in Chiltern Court, Henley. At the same time the Council was asked to commission 4 step-up beds to support people needing short term assessment under the care of the Rapid Assessment and Care Unit at Townlands Hospital.

46. From winter 2016-17 the Liaison Hub led by the hospital began to have oversight of the Council commissioned intermediate care beds and to place people discharged from hospital and then co-ordinate their onward discharge from the step-down beds.

47. From 1/11/2019 these 2 models (liaison hub and intermediate care beds) were brought together all commissioned by the Council:

    a. 56 Short stay hub beds commissioned from the Oxfordshire market.
    b. 41 intermediate care beds within the OSJ contract aligned to the Short Stay hub bed model.
    c. **97 beds in total November 2019**

48. In addition to these beds the Council
    a. would typically purchase 20-25 "interim beds" each winter for social care assessment outside of hospital.
    b. during the Covid pandemic response we additionally purchased up to 20 "covid designated beds" which ran to Mar 2022 for non-symptomatic but positive patients
    c. in both winter 20/21 and 21/22 we purchased 20 hotel beds with care to support flow.

Responding to demand and capacity pressures and reviewing discharge pathways

49. The overall performance of the Oxfordshire emergency health and care system is overseen by the Urgent and Emergency Care Board. The Board authorises the trajectories that we set against Better Care Fund and NHS Urgent Care metrics. It reviews performance and holds system partners to account and requires actions to address variations to planned trajectories.

50. The specific numbers of short stay hub beds have been flexed up and down in line with system demands in operational decisions made by the Council in partnership with the system and endorsed by the Urgent and Emergency Care Board. For instance, in August 2022, 17 beds were closed in line with operational demands at that point. Since then, there has been a core of 39 short stay hub beds and 41 intermediate care beds with capacity scaled up and down from time to time in line with Council contract provisions.

51. The Short Stay Hub Bed model was an emergency provision in reaction to acute hospital pressures which was developed into what the NHS Hospital Discharge Policy now defines as "pathway 2 reablement beds". Different local health and care systems have different models of discharge beds often derived from responses to immediate pressures at points in time. The national policy challenges this short-term reliance on beds and

asks us to see the patient as a person who would choose and would benefit from getting back to her own home as soon and as safely as possible.

52. Oxfordshire's historic heavy reliance on beds was derived from:

    a) A lack of reablement and domiciliary care alternatives to get people home.
    b) A system culture where beds were available and could be deployed and so relied upon to get the system moving when the hospital system was in danger of becoming overwhelmed. If in doubt we would buy a bed.

53. Oxfordshire has changed its approach to meeting the needs of people in hospital and we are now moving away from the bed-based discharge model. The system, in the Urgent and Emergency Care Board will continue from time to time ask the Council and other partners to scale up and down beds and other forms of provision in response to demand and capacity pressures, but our trajectory is to reduce beds and repurpose the ones we retain if indicated by the work we are doing to refresh the Better Care Fund plan for 2024-25.

54. Changes to the number of short stay hub beds will be determined operationally and managed by the Council within its contracts. This is considered business as usual activity.

55. Changes to the model of step-down beds would be subject to a wider engagement with providers, clinicians and users and their carers. If any changes are indicated they would probably lead to an open-market procurement exercise for interested providers to bid, but that would form part of the business case to support any changes.

Quality and financial impact of Home First Discharge to Assess

56. As set out above, where people don't need to be in a bed there are harms from them remaining in one. Where people do need a bed, it is much the better option that they are in their own bed at home.

57. Oxfordshire's strong performance on reablement outcomes in helping people get to independence and/or reduce care packages tells us we can support people appropriately at home. The numbers of people who use a short stay hub bed who end up at home with no care, or with reablement informs us that we have an opportunity to take some of those people "home first" rather than via a bed. The numbers of people who we have taken home under the Discharge to Assess pilot who have needed no care or have entered reablement when they would otherwise have been at risk of harm in a bed tell us that we are doing the right thing.

58. There is nothing wrong with a step-down bed when it is needed, and it will be the appropriate pathway for some people. However, by rethinking how we might support people at home (e.g. with live in or waking nights care) and by working with the rest of the system in the development of Integrated Neighbourhood Teams we can remove some of the risk and anxiety about supporting people home.

59. The economic case for taking people home is straightforward.
    a. A reablement episode costs <£1200 per person supported and generally people are supported for 2-3 weeks.
    b. where people are discharged and then become independent within 72 hours or move to long-term care, we are paying £250 as an episode cost for that 72-hour period.

c. By contrast, a Short Stay hub bed typically costs c £12-1400 per week with GP medical cover costs on top of that, and our target is that people are resident for up to 21 days.
d. If someone could go home, it may cost us £1200 with all the benefits to the individual of being at home. If she was placed in a short stay hub bed it will cost at least £4000 per episode. We may then have to additionally put in reablement to get the person home.

Home First Discharge to Assess-the way forward

60. A move from a bed-based to a home-based discharge pathway is safer for patients, delivers better outcomes and will be more economically effective over time.

61. These changes are not risk-free but the whole approach is based on positive risk taking to support better outcomes for the individual and the system. We have strong system leadership and partner commitment to making it work.

62. We are developing community- based resources that support more preventative approaches to help people at risk of going into hospital. This approach is underpinned by and consistent with the Oxfordshire Way, our approach to enabling people to remain and thrive in their own homes and within their own communities. How we respond to people after a stay in hospital should not undermine this ambition.

63. The development of the model needs to be better understood by our population and by stakeholders outside of the immediate urgent and emergency care system. HOSC can play a crucial and timely role in communicating and explaining this vision to a wider audience.

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