Oxfordshire Integrated Improvement Programme

Improving care for people who need inpatient rehabilitation or intensive community support

A progress report for the Oxfordshire Joint Health Overview & Scrutiny Committee (JHOSC)

January 2023

Contents

Executive summary

This paper sets out the system partnership work completed to date to develop the case for change for the redesign of community inpatient and intensive community support services across Oxfordshire. It builds on previous public and stakeholder engagement work and data analysis to understand and clarify the changes needed to address these elements of care, as part of the integrated improvement programme for community services across Oxfordshire.

The Oxfordshire Joint Strategic Needs Assessment and recent census shows that the population of Oxfordshire is growing, ageing and, on average, living with more complex care needs. Historically, rehabilitation services for people with frailty have been based on people receiving care within inpatient settings. In recent years, however, development of new Urgent Community Response (UCR), 7-day community reablement and patient discharge and flow teams has shown, evidenced through performance data and service user feedback, what more we can do more to care for people successfully at home.

Our review illustrates that these services are not sustainable as currently configured due to:

- Insufficient capacity to meet need – many patients experience significant delays in their discharge from acute hospital
- People increasingly have multiple care needs which mean staffing ratios have increased, leading to recruitment and financial sustainability challenges for services
- Patients and carers report that care is not joined-up and services need to be better integrated and coordinated, to improve people's experience of care
- Workforce pressures are leading to inconsistent service provision and variability
- Lack of capital investment in community estate over many years is now limiting service efficiency and facilities no longer meet the needs of patients and staff
- The need to move to a 7-day working to maintain system capacity and flow has required changes to staff working patterns, in order to provide safe and reliable services 24-hours-a-day, 365-days-a-year.

In recent years there has been a significant shift in health and care service development, recognising the importance of providing more care at home. There is a strong consensus among health and care professionals that to avoid a deterioration in mobility and loss of independence, most older and frail patients should be enabled to return home promptly when they no longer require hospital care and have achieved their inpatient rehabilitation goals, rather than remaining in a hospital bed. This is supported by an extensive evidence base showing that early supported discharge and reablement is better for long-term patient outcomes and health system performance (e.g. Prof John Bolton's work on discharge pathways[1], NHS Home First policy[2]).

In recognition of the benefits of providing more community-based care, there has been a national and local move toward the development of 'care closer to home' services. In Oxfordshire, this incorporates a range of new approaches developed and piloted by the health and care system partners, including 'virtual wards'[3], transfer of care hubs, enhanced hospital-at-home and urgent community response teams.

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[1] Developing a capacity and demand model for out of hospital care | Local Government Association

[2] NHS England » Principle 5: Encourage a supported 'Home First' approach

[3] A virtual ward provides support in the community to people with more complex medical and social needs. It enables the delivery of care and organisational approaches of a physical hospital ward to be delivered to a group of patients in their own homes, by a visiting team of expert staff. For more information, see: https://www.england.nhs.uk/virtual-wards

The acute virtual wards catering for people who require urgent care that previously had to be provided in hospital will be supported by same-day diagnostics and expert clinical assessment. In future, this will be provided through a number of Same Day Emergency Care units (also known as SDECs) which work closely with visiting Hospital-at-Home teams. All of these innovative services are explained in detail later in this document.

Complementary to these developments, a clinical and operational review of community hospital inpatient pathways was undertaken by the system partners; this commenced in late 2021 with a set of system workshops led by Oxfordshire CCG (the workshop reports are included in Appendix 4). The aim of this work was to develop a vision for the optimal service model based on the latest evidence and specialist expertise, that will enable patients to maximise their independence and improve quality of life. These expert groups recommended that community inpatient care should be focused on delivering clearly defined outcomes through more specialised, goal-focused pathways where staff skills and training, care interventions and the therapeutic environment are optimised to meet the needs of the cohort of patients they support.

This work also identified opportunities to deliver care differently in our community hospitals, where this provides additional benefits to patients. Specific examples include developing community hospitals to support more outpatient and therapy services (such as the services being piloted at Wantage Community Hospital), co-location of Children and Family services and development of health and wellbeing hubs to host the voluntary and community sector and provide local access to digital services.

In addition to improving the use of community hospital buildings, there are increasing opportunities to use digital technology to better understand and support patients at home, for example increased monitoring equipment within the community. At a time when health and care services are under unprecedented levels of pressure, it is essential to align services to reduce any potential duplication. This includes consideration of how we can work better with the third sector and ensure services are aligned with whole population needs.

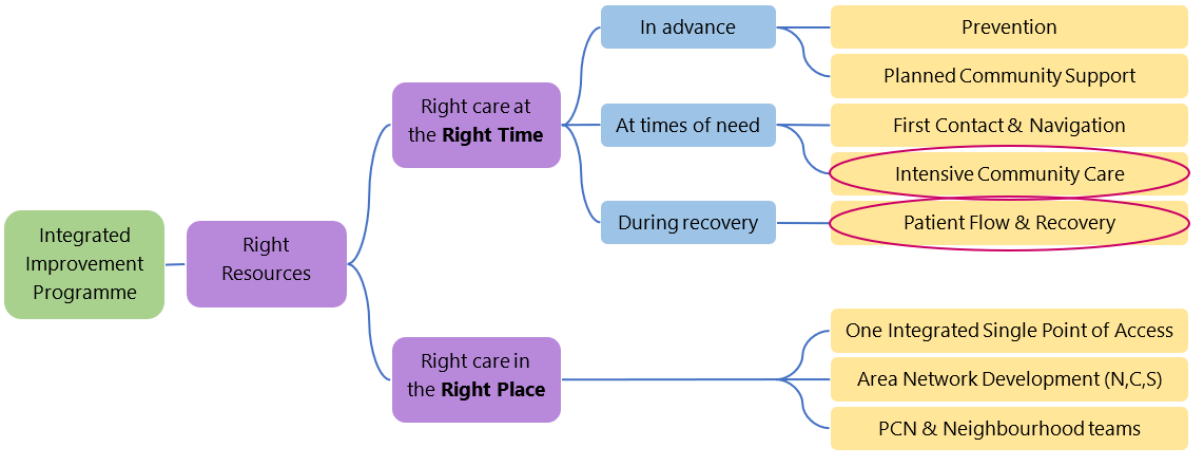
To move this work forward it is now proposed that the following steps should be taken:

- Finalise the case for change and confirm organisational support from system partners and stakeholders
- Work with stakeholders to develop options and plans to operationalise the integrated community-based care model to provide both virtual ward care, community hospital inpatient care and same day assessment, incorporating public feedback
- Complete an options appraisal with stakeholders and agree recommendations for implementation of the improved model for community hospital inpatient care
- Work with local stakeholders to apply the above work to local areas and sites, including making a formal decision on the future of Wantage Community Hospital inpatient unit.

Introduction

Strategic alignment

This paper provides an update on the progress made in developing the case for change for inpatient and intensive community support services within Oxfordshire. This covers the intensive community care and patient flow & recovery elements of the integrated improvement programme (see appendix 1 for full programme structure):



Programme	**Project**	**Project Objective**
Intensive Community Care	Intensive community care pathway	A 24/7 integrated intensive community care and support pathway for Oxfordshire (including Acute Virtual Wards)
Patient Flow & Recovery	Modernising Community Hospital In-patient rehabilitation and care	To develop costed plans and options for Community Hospital inpatient pathways that address changing population needs, best practice, workforce and financial sustainability challenges
	Transfer of Care Hub	To create a single integrated Transfer of Care Hub Team across the partner organisations / different inpatient settings to streamline flow, discharges and provide a joined-up view on the best use of available beds and resources

The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Partnership (BOB ICP) is developing a strategy to further develop the local health and care system and reduce inequality. The members of the ICP have worked with partner organisations, the voluntary sector, and other stakeholders to understand their areas of focus. The ICP has launched public engagement to seek feedback on these proposed priorities from wider partners and with people who live or work in Buckinghamshire, Oxfordshire and Berkshire West.

The draft strategy proposes priorities in the following categories:

- Promoting and protecting health – to support people to stay healthy, protect people from health hazards and prevent ill-health
- Start Well – to help children achieve the best start in life
- Live Well – to support people and communities to stay healthy for as long as possible
- Age Well – to support people to live healthier, independent lives for longer
- Improving quality and access – to help people access services at the right place and right time.

The service changes discussed in this paper are closely aligned with the principles set out in the draft strategy and are of particular relevance to the 'Age Well' section – to support people to live healthier, independent lives for longer. In addition, the development of community hospitals to support health and wellbeing hubs, and the expansion of local outpatient and therapy clinics, will directly support the promotion and protection of health in the community.

The next step for the BOB ICP strategy is to work with local people and communities to set the direction and agree a common set of priorities for the partnership, linking with plans already in place, to meet local needs while sustainably managing the growing pressure on services.

Previous work (including the OX12 project)

(See appendix 2 for further papers relating to engagement carried out to date)

This paper builds on a substantial foundation of previous work over the past 5 years.

The OX12 Project tested and utilised the Oxfordshire Health and Care Needs Framework to identify the health care needs of the OX12 population; this work indicated that in general these needs were being met though there were some issues that could be considered for improving access. The expected September 2020 deadline advised in February 2020 was completely overtaken by the essential NHS response to COVID in a level 4 Pandemic where the entire NHS was instructed to drop all non-COVID/non-priority work in a National Command and Control incident management structure. Since then, this work has been picked up within the community services strategy work which is encompassed within the integrated improvement programme.

The COVID period showed that we can deliver different solutions if we innovate and recognise each individual's strengths. It demonstrated that it was possible to shorten lengths of stay, reduce delays, and avoid admission to hospital. There has been continued work in OHFT to build on the evidence base plus the system experience of doing things differently through COVID, for example through the implementation of the urgent community response service. This work builds on best practice and this learning and applies it to all our services for older adults including the Wantage area.

In June 2021, a review of engagement to date (see Appendix 2) identified the following key feedback in relation to services for older adults identified the following priorities:

- Staying healthy and active along with support to tackle loneliness and isolation, and access to appropriate healthcare and local services
- Maintaining independence; people want to stay at home for as long as possible if you become unwell or need care
- More advice about how to stay healthy, how to manage financially as people get older and how to navigate the complex care pathways from the health, social care and community sectors
- Better access; getting to health appointments by public transport is often challenging (particularly from rural areas) and it can also be difficult by car due to traffic congestion and problems parking.

Building on this work, some focused public and stakeholder engagement was carried out in winter 2021-22 to develop principles for shaping services for community services in Oxfordshire, which were subsequently ratified by the Oxfordshire Health and Wellbeing Board. This work included a number of public discussion events facilitated by Healthwatch Oxfordshire. Full details of the feedback on this work can be found in at appendix 2.

The models described in this paper, support the delivery of the following principles developed to shape community services in Oxfordshire:

- Principle 3: Enable people to stay well for longer in their own homes.
- Principle 5: Ensure our use of beds in the community maximises improvements in people's long-term health.
- Principle 6: Base service design on best practice, clinical evidence and user experience
- Principle 7: Organise services so staff operate in teams with appropriate skills and in buildings that enable them to work more effectively
- Principle 9: Deliver the locally and nationally agreed priorities for our health and care system
- Principle 11: Maximise the positive impact on health and wellbeing for our population, within the limitations of our resources

Local Context

The needs of local people (Oxfordshire JSNA 2022)

This work builds on the areas of focus which have are set out within the Joint strategic needs assessment for Oxfordshire. Specifically, 4 key population trends relating to older adults have been identified which will need to inform the way in which we deliver community health and care services moving forward.

1. The population of Oxfordshire is growing

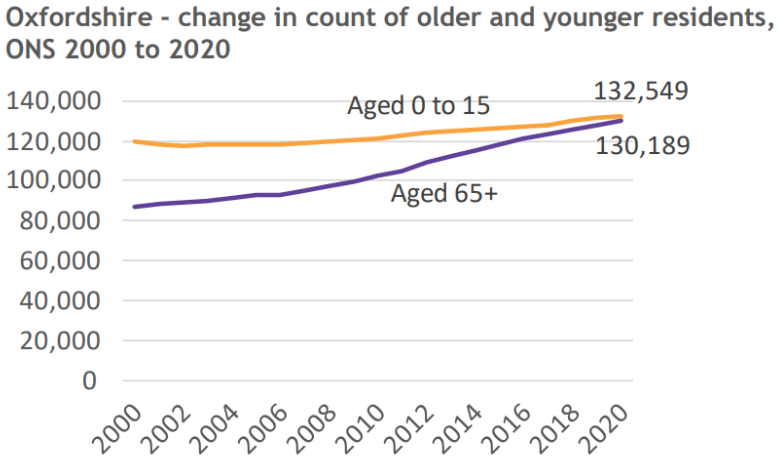
On Census Day, 21 March 2021, the size of the usual resident population in Oxfordshire was 725,300. Oxfordshire's population grew by 71,500 (10.9%) since the last Census in 2011 when it was 653,800 residents. This increase in Oxfordshire was above the growth across England (6.6%).

Looking ahead, Oxfordshire County Council's (OCC) housing-led forecasts (interim-2020) estimate a total population of 801,700 in Oxfordshire by 2028, a growth of 110,400 people over 10 years.

2. Overall, the Population is getting older

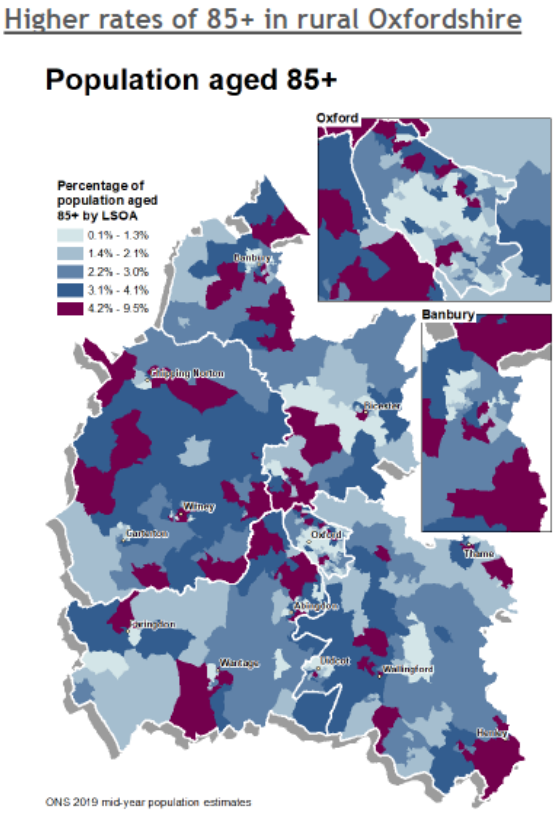
The JSNA completed in 2022 identified that older people make up an increasing proportion of the population. Between 2002 and 2022 the older age group, aged 65 and over, increased by 50%. In addition, much of this older population is based within rural areas of the county.

In 2020, older people aged 65+ made up 20% of the estimated population of Oxfordshire's four rural districts, compared with only 13% of the population of Oxford City. Community healthcare therefore need to be updated to meet the growth in this population.



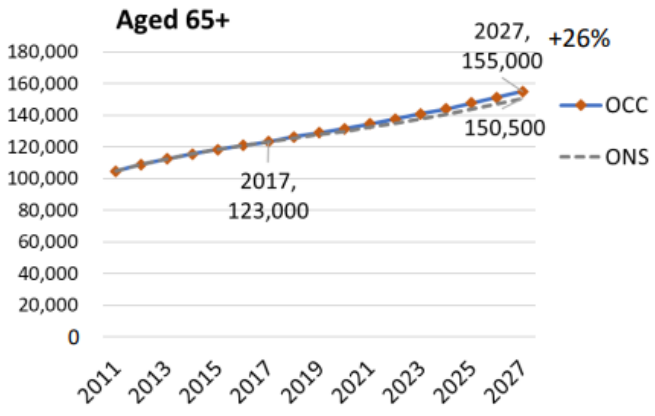
3. A lot of our older population live in rural districts

The rural districts in Oxfordshire have a much higher proportion of older people than Oxford City. In 2018, people aged over 65 years were estimated to make up 20% of Oxfordshire's four rural districts, compared with 12% of the population of Oxford City (18% overall).



4. People are living longer, with increasingly more complex care needs that require more support from health and social care services

The oldest population group, those aged 85 and over, are particularly high users of community services including community nursing and therapy, frailty, falls prevention, home care, care home and reablement services. This group is predicted to increase from 17,847 in mid-2018 to 22,020 by 2028, an increase of 4,173 people (+23%).



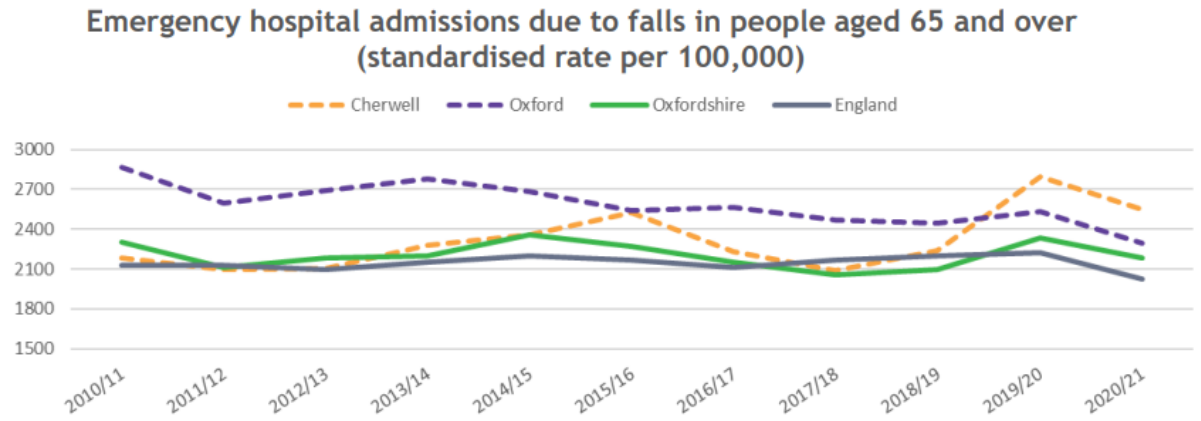
Assuming the use of health and social care services remains at current levels for the oldest age group (85+) would mean the forecast population growth in Oxfordshire leading to an increase in demand of:

- +7,000 additional hospital inpatient spells for people aged 85+: from 12,600 in 2016-17 to 19,600 in 2031-32.
- +1,000 additional clients supported by long term social care services aged 85+: from 1,900 in 2016-17 to 2,900 in 2031-32

The Family Resources Survey provides national disability estimates annually which can be scaled to Oxfordshire using population numbers. In 2018/19 around 19% of people in the South-East region had an identified disability, equating to around 131,400 people in Oxfordshire. The most common types of disability for adults over 65 is mobility impairment.

According to Public Health England, falls are the largest cause of emergency hospital admissions (nationally) for older people, and significantly impact on long term outcomes, e.g. being a major reason why people move from their own home to long term nursing or residential care. In 2020-21 there were 3,005 hospital admissions due to falls in people aged 65 and over in Oxfordshire.

The rate of hospital admissions for falls in older people is higher than national rate (2,186 per 100,00 population in Oxon compared to 2,023 in England).



As of 1 April 2022, there were 5,954 adults in Oxfordshire receiving ongoing long-term social care from Oxfordshire County Council, down from 6,197 on 1 April 2020 (-3.9%). The majority (60%) of Oxfordshire's ongoing long-term social care clients were older people aged 65 and over. 16% were aged 90 or over. Just over a quarter (27%) of people receiving social care support are people with learning disabilities.

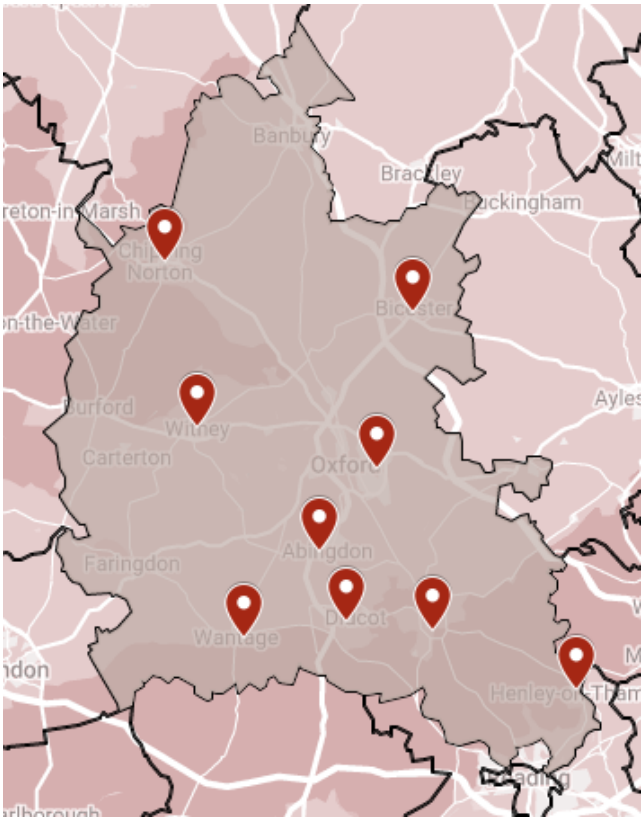
Applying the current rate of older people (aged 65+) provided with long-term social care (i.e. assuming no change in prevalence) to population forecasts/projections gives a potential change by 2030 of: +900 (3,800 to 4,700, rounded) from 2020 to 2030 based on Oxfordshire County Council population forecasts including housing growth +900 (3,800 to 4,700, rounded) from 2020 to 2030 based on ONS trend-based population projections.

Current community services

Community hospitals located in Oxfordshire

Oxfordshire's Community Hospitals provide a range of important services and facilities that support care within the community. At some sites, this includes inpatient (bed based) and outpatient (clinic based) services. Community Hospitals also serve as local bases for teams providing outreach and home visiting services.

Community Hospital inpatient units support the recovery of patients who require a period of inpatient rehabilitation and nursing care and no longer require the treatment available only in an acute hospital. A key aim is to enable people to achieve their potential to resume independent living at home. Oxford Health NHS Foundation Trust (OHFT) delivers community hospital inpatient care in eight community hospital wards located at six sites across Oxfordshire, with a 9th ward at Wantage Community Hospital temporarily closed in 2016.



Locations of the Community Hospitals within the Oxfordshire 'Place' of the Buckinghamshire, Oxfordshire & Berkshire West Integrated Care System.

NB. Services at Thame Community Hospital are commissioned through the Buckinghamshire Place.

The cohort of inpatients in Oxfordshire's community hospitals includes people who require a period of specialised nursing or therapy; for example, to support recover from stroke, severe frailty, delirium, ill-health requiring hospital treatment, surgery and bariatric (plus-sized) care. Our community hospitals also provide care to people at the end of life who need round-the-clock nursing care or symptom control but who, for a range of different reasons, are not able to receive this care at home or in a hospice.

These community hospital wards employ a varied skill-mix and range in scale. Some support ambulatory care pathways, enabling direct admission from the community, while others are more focused on inpatient rehabilitation for patients stepping down from a period of acute hospital inpatient care.

It is important to note that the number of beds 'open' at each community hospital fluctuates each week and is determined by a number of clinical and operational factors. This includes the level of need of the patients on the ward and the corresponding staffing ratios of medics, nurses and therapists required to provide safe and effective care and deliver their therapy. This is continuously monitored and adjusted in response to a number of factors, including:

- The acuity and care needs of patients on the ward (i.e. the severity of illness in the current cohort of inpatients and their corresponding level of care need)
- The number of patients requiring double-handed nursing or therapy interventions
- The number of people requiring plus-sized/bariatric care
- Current pressures on the capacity of acute hospital and home care/reablement services
- Responses to surges in infectious disease
- Changes in seasonal demand (e.g. 'winter pressures')
- Changes in infection prevention and control guidance (e.g. COVID-19 bed spacing and social distancing requirements)
- Available staffing levels (e.g. high staff sickness levels or long-term vacancies)

In December 2022, the following community hospital beds were operating across Oxfordshire:

Community Hospital Inpatient Units	Bed numbers
Abingdon	38
Abbey Ward – General	*12*
Abingdon – EMU (subacute)	*6*
OSRU (stroke rehab)	*20*
Bicester – *General*	12
Didcot – *General*	18
Oxford (City Comm) – General	15
Wallingford	18
General	*16*
End of life	*2*
Wantage (temporarily closure)	-
Witney	32-33
Linfoot – General	*8-10*
Linfoot – Bariatric	*3-4*
Wenrisc – EMU (subacute)	*4*
Wenrisc – General	*16*
Total	**133**

In addition to beds provided by Community Hospital inpatient units, a variable number of community beds are commissioned within care homes for patients who are medically fit for discharge but require a period of bed-based reablement (known as 'pathway 2' in the national Discharge-to-Assess model). These are known locally as 'short stay hub beds'. Patients in these beds are supported by healthcare workers, nursing and therapy professionals but there are lower ratios of medics, nurses and therapists compared to a Community Hospital, reflecting their different needs.

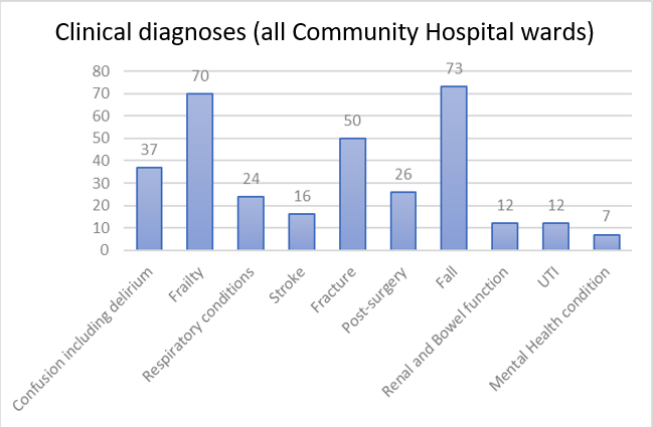
In 2021 a census of the current role of community hospitals inpatient beds was completed to assess which patients were being cared for in inpatient settings, what needs they had and where they usually lived.

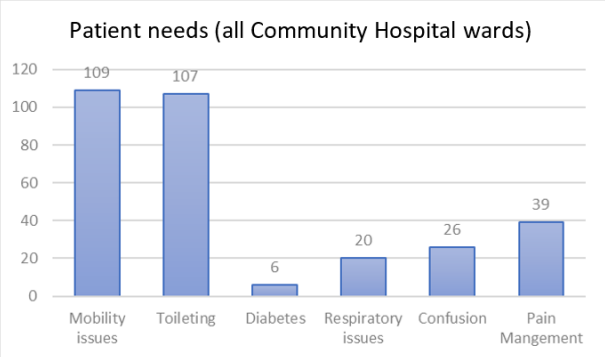
The reason for admission into community hospitals is defined within a set of 'criteria to reside'. These admission criteria are based on the information provided at the time of admittance; this may not reflect fully the needs of the patient during their time at a community hospital.

At the time the census was completed the majority of patients had been admitted due to being highly dependent or having increased dependency. These criteria are defined as:

- Highly dependent: The person currently has a significant level of dependency that requires 24-hour support and are currently unable to return home without significantly impacting on their future long-term recovery e.g. needing assistance of 2-3 people to transfer and showing good progress in recovery.
- Increased dependency: The person is showing a higher level of dependency and unable to return home with the current level of support available or where behavioural issues are impacting recovery.

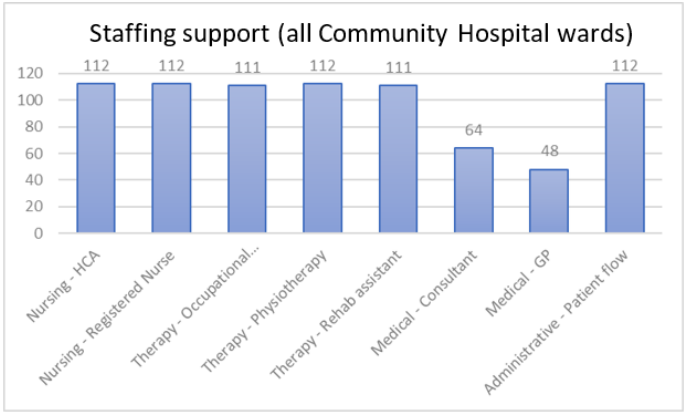
The review in 2021 identified nearly 1000 diagnoses (ICD10 codes) associated with patient cohorts who use Oxfordshire's Community Hospital beds. To break these down into more significant groupings the census diagnoses categories were based on an initial test census which reviewed all diagnosis and needs captured which were then grouped into themes. These were defined as 'main needs' and 'main diagnoses'. The most common clinical diagnosis was frailty followed by falls although there were also a high proportion of patients with fractures and a high level of confusion. It is important to note that patients within these settings often have many interrelated conditions, in addition to the main diagnoses noted here there were, for all patients, a total of 218 additional diagnoses recorded across patients within the community hospital.





The most common patient needs within community hospitals were related to mobility and toileting. This aligns with the rehabilitation most commonly provided which focus on addressing challenges around mobility and personal care to enable functional independence. Mobility includes bed mobility - ability to roll, lying to sitting, sitting over the edge of the bed, moving up and down the bed, sitting to lying. Transfers between bed, chair, commode, toilet, wheelchair. Mobilising- in a wheelchair, with equipment of some kind.

As part of the census, we also reviewed the staff who provide support to all patients within all settings. All Community hospital patients were receiving support from Health care assistants, Registered nurse, Occupational therapist, Physiotherapist, Rehabilitation assistant & Patient flow team. Medical cover was divided between GP & consultant. In addition, but not captured in the census, medical cover is also provided by Advanced Clinical Practitioners in Didcot, Bicester and City wards. Due to staffing limitations, Therapists within Hub beds are expected to work across disciplines e.g. a Physiotherapist providing Occupational Therapy and vice versa. All short-stay hub bed medical cover is provided by GPs however some patients are supported by Ambulatory Outreach Team or the Ambulatory Units at the JR and Horton hospitals.



Urgent Community Response Service

Community beds make up only a small part of the community services offer. Services in people's homes are central to supporting the wider population to remain as healthy as possible and reduce lengths of stay in acute hospitals.

The intensive community care pathway, of which the urgent community response is part, is focused on reducing the number of people who require admission to an acute hospital bed. This has a significant impact on the way in which people are supported within their own homes and reducing the need for community inpatient rehabilitation. Further details are available on the NHS England website: https://www.england.nhs.uk/community-health-services/community-crisis-response-services/

This service is available 08:00-20:00, 7 days a week and delivers:

- a crisis response service within two hours of referral, avoiding the need for unnecessary hospital admission and supporting same day emergency care
- reablement care within two days of referral reducing unnecessary hospital stays

Preventing admissions and providing care at home is critical to managing hospital capacity and to improving outcomes. Many people with frailty currently admitted to hospital through A&E don't need inpatient care – estimates range up to 30%. The 2018 National Audit of Intermediate Care recommended that intermediate care capacity needed to double to meet demand and that waiting times for crisis response were on average 5.1 hours and for reablement were 5.6 days[4].

The patients referred to the UCR for a 2-hour response can be broadly grouped in to three areas:

1. Frail and unwell: approx. 41% The patient is dizzy, or has fallen, or is confused or has an underlying health condition that has become worse, and a full physical assessment is required.
2. Mobility problems: approx. 33% The patient is unable to cope with general daily activities and requires a full physical assessment to find the cause. They may also require some provision of equipment.
3. End-of-life: approx. 9% The patient has been referred for one of the above and after the full physical assessment is identified to be approaching end-of-life and are referred on to other more appropriate services

A short summary of the UCR service is available at: https://www.youtube.com/watch?v=Nks24V5QENk

[4] Slide 1 (careengland.org.uk)

Patient flow through hospitals and the Transfer of Care hub

Community hospitals have an important role in maintaining 'flow' through the whole health and care system. To do so, their staff must engage with health and care colleagues to receive patients proactively, ensure that care processes are effective and efficient throughout the patients stay, and arrange timely discharge from hospital at the earliest point that can be safely achieved.

The overwhelming majority of patients come to the community hospital having first received their care within an Acute Trust. There is an increasing evidence base detailing the benefits of early discharge from hospital, though it is clear that for some rehabilitation and recovery with sub-acute medical needs will still require non-acute hospital care. Care is a joint endeavour between patients, their families and the staff who care for and support them. A key priority is to ensure that families and carers are seen as a true partners in care, where this is desired by the patient.

The case for modernising our bed-based model

Patient admission locations for Community Hospitals

The admission location of patients is determined currently based on the needs of the patient combined with the availability of a bed within the patient's local community hospital. The maps in appendix 3 show the home locations of the patients admitted to each Community Hospital Inpatient Unit between April-October 2021. Although preference will always be given to a patient being placed closer to home, there are a number of factors which may influence the location to which a patient is admitted and currently a high proportion of patients within all inpatient settings are not admitted to their local community hospital. The need to move a patient out of an acute hospital bed so that it can be allocated to another patient may result in them being admitted to another community hospital which has can meet their needs at that time. It is important to note that Abingdon, Witney and Wallingford Community Hospitals provide some services which serve the whole county and so the location of patients would be expected to be more widely distributed

People are having to wait for care

The pressures facing both the NHS and social care currently are well reported on and are having a very significant impact both at a national and a local level on the quality of care that services are able to provide. Perhaps most visibly, this is reflected in the length of time which people who need emergency care are waiting. For example, in Oxfordshire in December 2022, 47% of people were waiting more than the 4-hour target time as a result of the high levels of demand. Perhaps less visible but equally challenging this pressure is also resulting in patients across the NHS having to wait longer to return home or to a care home after an admission to hospital. Within Oxfordshire Community Hospitals, during 2022 it was usual for between 20-50 people who were still on the ward to no longer met the criteria to reside in hospital (data reported monthly to Oxfordshire A&E Delivery Board).

Increased complexity of care needs

With increases in the older population, more people in the community are living with one or more long-term health conditions. Many services were commissioned to manage specific illnesses rather than the whole person. This means that people with multiple conditions can experience disjointed care which can result in an individual having to have contact with multiple different services. People with one or more long-term condition need high quality, consistent and integrated health and social care. People with more than one condition, or who have a long-term condition when something else happens to impact on their health (such as having a fall), often require more complex support. Health and social care services need to be better designed to respond to these needs.

Workforce recruitment and retention

Like many other parts of the NHS, community services are facing significant challenges in recruiting and retaining sufficient staff to meet the needs of the population. Central to addressing this challenge is ensuring that staff teams are supported to have an appropriate workload and mix of skills to be able to meet patient needs. Over the past 2 years Oxford Health have invested in both our community urgent community response and community hospital staffing teams to increase their resilience. As part of this a project to reduce use of agency staff has developed an international nursing recruitment campaign which has enabled us to reduce vacancy rates within staff teams. In order to maintain staff retention however it is necessary to ensure services are both financially sustainable and there is sufficient capacity to meet the demand for services.

It is also important to note that where a ward has only a small number of beds it is much harder to maintain a core team to provide sustainable staffing, which can impact on the ability of that environment to provide optimal care. To ensure wards can be staffed appropriately to meet patient needs, consideration needs to be given to a viable ward size and smaller units have higher running costs on average.

The Lord Carter review (2018) noted that "a much clearer idea of 'what good looks like' is needed but one thing is certain – an isolated 10-bedded inpatient facility is unlikely to be clinically or financially secure"[5]. In order to provide a safe and sustainable service, it is recommended that a minimum staffing level (equivalent to 15-20 general beds) should be maintained on each site, so it is neither clinically safe nor sustainable from a workforce perspective to further reduce the bed-base by a small number across all the community hospital wards.

Financial sustainability of services

Care Quality Commission (CQC) research (2018) has shown that investment in lower-level preventative services can lead to a reduced need for care and support and cost saving equivalent to £880 per person. Therapy-led reablement is proven to reduce need[6]. In order to increase the financial sustainability of community services it is therefore necessary to review the way in which we deliver services to ensure we are achieving the best patient outcomes within the financial resources available to the NHS and move from bed-based crisis care towards a more preventative approach based within the community.

The amount of funding available to community services has not risen in line with the ageing population and increased complexity of needs. In addition, the challenges associated with staffing are resulting in higher use of agency and temporary staff which is both more costly and less good for patients.

The result of these factors is that the current model of care delivered within the community hospitals across Oxfordshire is no longer financially sustainable. This, in combination with the withdrawal of covid-related monies, has resulted in a service forecast deficit of nearly £6m in financial year 2022-23.

The 'safer staffing', Improving Quality Reducing Agency, and other reviews carried out by Oxford Health NHSFT indicate that, with efficiency savings, the current funding envelope can sustain a workforce to maintain a bed-based of 115-120 inpatient rehabilitation beds across Oxfordshire in FY24, with an average length of stay of 26-28 days and around 1600 admissions per year. This compares to around 133 beds open currently in 8 inpatient wards in December 2022.

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[5] Lord Carter review (2018)https://www.england.nhs.uk/wp-content/uploads/2019/09/20180524_NHS_operational_productivity_-_Unwarranted_variations_-_Mental_....pdf p3

[6] Evidence review for adult social care reform (publishing.service.gov.uk)

In summary, three options have been identified to address the financial challenge which will need to be considered by the Integrated Care System as part of any proposal to achieve sustainable community hospital services:

1. Review of the care model, with an increase in the funding envelope available for Community Hospital inpatient care aligned with optimised productivity and length of stay to maintain the average baseline of c.133 community hospital beds across the county

2. Review of the care model aligned with optimised productivity and length of stay while moving more care into the community and reducing the size of the inpatient rehabilitation service within Oxfordshire to c. 115-120 beds, to reach financial balance within the current funding envelope

3. Review of the care model aligned with optimised productivity and length of stay, with a system agreement to continue to run a substantial financial deficit within this service and cross-subsidise the service costs from other sources

Limitations to the community hospital estate

In addition to community hospital care being comparatively expensive to run, the buildings which these services are run from are often not cost effective or best suited to the needs of patients. A report produced in 2021 by NHS Benchmarking showed that Oxfordshire community hospitals are relatively inefficient to run compared to others, due to small unit size / old buildings. A number of community bed sites have limitations relating to their physical estate including parking, building size, design and age, and requirements to share space with other services. Future co-design of options and subsequent decisions on the optimum location for community beds will need to include a review of the physical estate constraints for each ward as well as consideration of any capital works which could be completed to mitigate these, and any travel impacts for patients having to travel between wards if smaller wards are seen to be less viable.

Move to 24-hour working

Nationally the NHS has committed to the ambition of delivering seven-day services to ensure that patients receive consistent high quality safe care every day of the week. This has been shown to have significant patient benefits and reduce variation in patient care. However, in order to move to this model, services need to either change how they provide services or increase staffing by nearly 30%. In order to deliver this model sustainably it is necessary therefore to review how services are provided and identify opportunities to align services better to meet patient needs every day of the week.

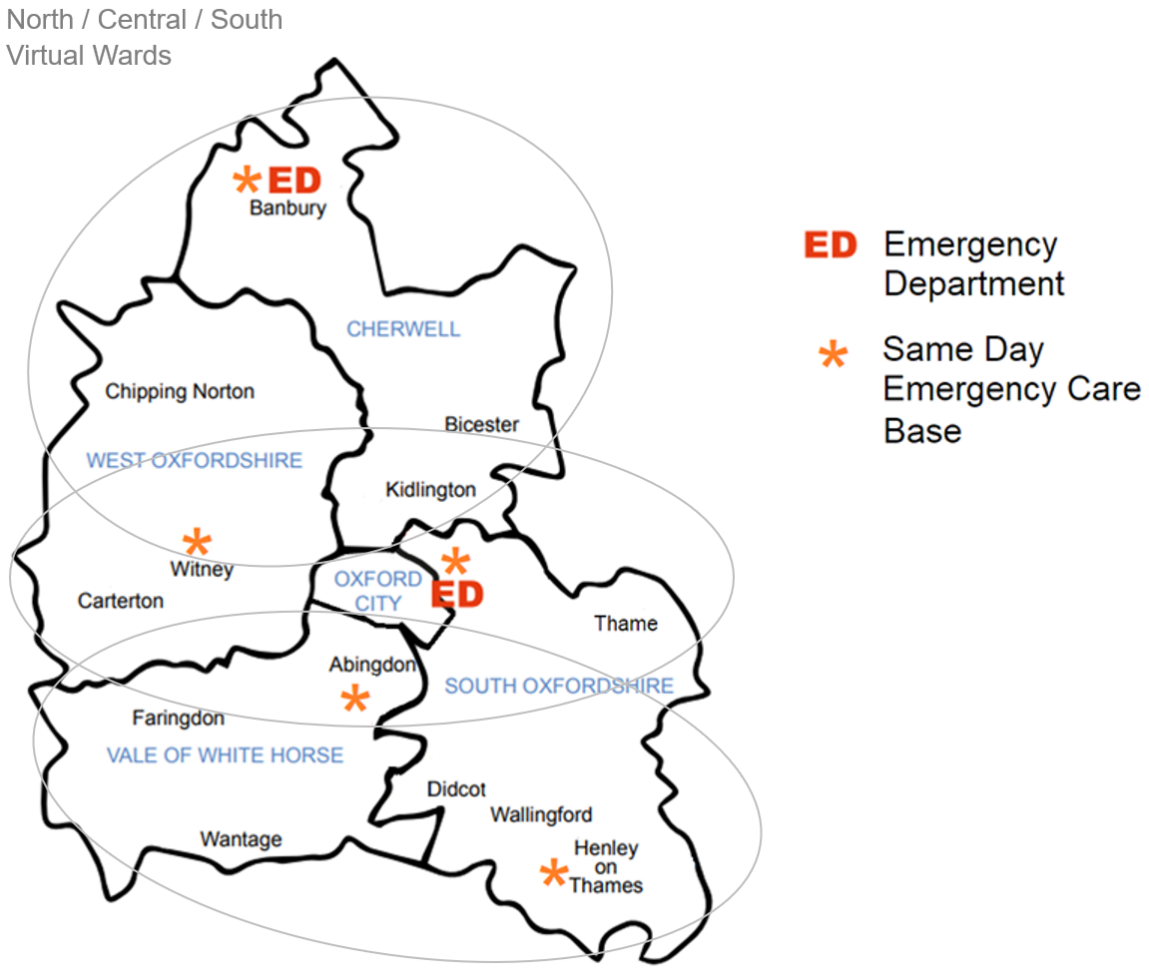
Opportunities for change

Urgent and emergency care – acute Virtual wards and Same Day Emergency Care units (SDECs)

Acute virtual wards allow patients to get the care they need at home safely and conveniently, rather than being in hospital. The NHS is increasingly introducing virtual wards to support people at the place they call home, including care homes. Within Oxfordshire this care is being delivered through community-based interventions such as hospital-at-home which is a service to enable people with complex health needs to remain at home. This approach has been shown to have a significant role in enabling admission avoidance. These acute virtual wards will complement the longer-term care being provided by GPs through the development of primary care virtual wards.

Over the next year NHS England has set out an ambitious programme of development for these services to provide 45 beds per 100k of the population. Within Oxfordshire this will build on the existing Hospital@Home services and align with the Urgent Community Response to develop a collaborative model of admission avoidance.

Map of developing acute virtual wards and existing same day emergency care units in Oxfordshire



In order to avoid the need for conveyance to hospital, it is also necessary to provide access to improved diagnostic facilities in the community. Although many tests can now be done in the home, virtual wards work best when they can refer patients to same day emergency care (SDEC) facilities – units where clinical expertise and diagnostic facilities can be concentrated.

Within Oxfordshire there are currently two types of SDEC, Emergency Multidisciplinary Units (EMUs) – currently at Witney and Abingdon community hospitals – and Ambulatory Assessment Units (AAUs) – located at the Horton and John Radcliffe hospitals. As part of the development of the new acute virtual ward model it is also recommended that consideration is given to reconfiguring the SDEC provision and how this can be aligned to the acute virtual wards in order to maximise admission avoidance, improve consistency of care across the county and support more people to receive care at home.

Proposed clinical care model for Community Hospital inpatient rehabilitation

As part of the work carried out to date, a clinically led review has been completed to identify the current and optimal clinical model for community beds within Oxfordshire (see Appendix 4). This was based on engagement over a number of months with clinicians and care professionals from across the bed-base and consideration of the national and local drivers for change associated with bed-based care within the community.

Within this process two stakeholder workshops were completed, facilitated by Emergency Care Improvement Support Team (ECIST). ECIST are the part of NHS England, who directly support health and social care systems to improve patient flow and safety and deliver national urgent and emergency care priorities. A summary of the workshop agenda and attendees can be found at Appendix 4. Building on these workshops a working group was put in place to develop a proposed clinical model for community hospital inpatient rehabilitation which is set out below.

Design principles

As a general principle, Community Hospital beds are best used to provide a period of expert therapy and nursing care which cannot be delivered effectively or safely in the home or a day care setting. This includes people with a 24-hour nursing need, or a therapy need which cannot be delivered at home; such as where an individual does not have the space for essential equipment or requires intensive support from multiple staff members.

The working group agreed that admission to a community bed should be based on:

1. The identification of a care, reablement or therapy need that cannot be met in the patient's usual home environment
2. The frequency and intensity of health care needs, i.e. how often the individual needs care
3. Diagnostic certainty and relative medical stability, i.e. how confident professionals are that the needs of the patient are understood and likely to remain consistent

In order to manage discharge to the community, a 7-day therapeutically focused approach should be implemented. This will reduce the extent to which discharges would be affected by the time and day on which a patient is due for discharge. For example, currently there are fewer patients discharged over the weekend period and planning for discharge is largely carried out within the day, this can delay the discharge of patients. In addition, a target estimated (currently called anticipated) discharge date will be agreed at point of admission and regularly reviewed through the multi-disciplinary team (MDT) discharge process.

As noted, the high level of demand for services within Oxfordshire means that it is important we are confident that beds are being used appropriately, alongside both acute care and care at home. For this reason, the following approach to determining whether someone's needs are best met within a community bed is recommended:

1. We will always consider first whether someone can return home and if their needs could be better met within the community.
2. No one whose care and health needs can be met at home at the time of discharge should be placed in a community bed. To inform this decision making, it is recommended that a frailty score could be used to assess the needs of each patient.
3. We will minimise wherever possible delays which result in people remaining in the bed when it is not the right place for them.

It is recognised that patient choice is important and should be considered as part of any decision making. However, choice will need to be balanced against the needs of all patients within the system. To ensure that both the patient and family are clear about how long a patient should remain in a community bed and how decisions on discharge are made, it is essential that staff work really closely with families to set expectations and be realistic about care goals. This will ensure that everyone is clear about what support is most appropriate. Community Hospital beds should not be used to provide respite provision as this is better provided within another setting, such as a care home.

Partnership between all staff involved in the care of the patient as well as close working with patients and their carers is key. This will need to include considerations around housing and where the patient is from. It is important that consideration is given to all organisations who can support strength-based approaches to community living, including the voluntary sector. Consideration will also be given to how we can support both formal and informal carers.

Staff will aim wherever possible to discharge people home with care rather than waiting until they can go home without a care package; it is recognised, however, that this is dependent on the capacity of home care and visiting services.

Overview of the proposed community hospital inpatient pathways

The following section sets out a clinical framework for the inpatient care pathways supported by Community Hospitals in Oxfordshire. These pathways form part of a continuum of service provision that spans home, community and hospital settings; they require suitably resourced and staffed community inpatient units to meet the needs of certain patients, in order to deliver the therapeutic interventions and outcomes that require a focused period of inpatient care.

In summary, six updated Community Hospital inpatient care and rehabilitation pathways are proposed:

1. Sub-acute medical care and stabilisation
2. Strength-based rehabilitation for people in recovery
3. Rehabilitation for people with bariatric needs
4. Specialist stroke and neurological rehabilitation
5. Specialist care at the end of life

Sub-acute medical care and stabilisation

- **The need:** People who become unwell, injured or whose health deteriorates and who have frailty, multimorbidity or complex needs, may require an actively managed period of stepped-up medical assessment and monitoring, medical treatment, nursing care or therapy in an inpatient unit until they are stabilised; but don't need the facilities of an acute hospital
- **Location**: Patients in this pathway require rapid assessment in an ambulatory care or same day emergency care unit, following by a period of monitoring and treatment from a suitably trained multi-disciplinary team of medical, nursing and therapy professionals. They also require access to diagnostic and imaging services, such as x-ray, and so these facilities should be co-located together. Because of these essential needs, it is necessary to provide this care on a limited number of specialised Community Hospital sites with appropriate staffing and facilities.
- **Examples of patients supported**:
    - An older person who is unable to walk due to unexplained weakness and has become slightly confused
    - A person with multiple health conditions who has become gradually more breathless and fatigued over the past week
    - A person with frailty who has been seen in an acute hospital and is well enough to return home, but requires a specific treatment and re-assessment by clinical team the following day

Strength-based rehabilitation for people in recovery

- **The need:** A proportion of people who have had a significant period of illness or immobilisation, including some people who are recovering from injury or surgery, need expert inpatient rehabilitation and/or nursing to reach strength-based goals within a target timeframe.
- **Location:** A period of bed-based reablement or rehabilitation is required by approximately 4% of all acute hospital discharges according to national models and should be made available to patients in all Network Areas of the county through a series of well-resourced, equipped and suitably staffed Community Hospital inpatient units.
- **Examples of patients supported**: People with multiple care needs and diagnoses (co-morbidities) who require full time care and therapy to be rehabilitated. Examples might include a person who was:
    - Admitted to hospital following a fall which caused multiple fracture admitted for rehabilitation. Rehabilitation limited due to pain and postural hypotension
    - Admitted to an intensive care unit and is recovering from post ICU deconditioning in addition to having general frailty
    - Admitted following a fall with a history of reduced mobility and who also has a learning disability
    - Admitted with respiratory issues post COVID-19 and associated pneumonitis, struggling with fatigue and multiple wounds/pressure ulcers.

Rehabilitation for people with bariatric needs

- **The need:** There is an increasing number of people with a high BMI who require specialised equipment, facilities and professional input to enable them to experience safe and effective rehabilitation, so they can return home and access appropriate support for weight management as well as other health and wellbeing needs
- **Location:** This cohort requires use of specialised equipment, premises adaptations and staff trained in providing care for plus-sized people. As a result, it is necessary to provide this care on a limited number of specialised Community Hospital sites with appropriate staffing and facilities.
- **Examples of patients supported**:
    - A person with a BMI of 40 who has had a fall causing toe fractures and is immobile. Previously transferred with pivot transfer but unable to do so with fractured toes so needs significant support.
    - A person with a high BMI who is recovering from a below knee amputation.
    - A person with a high BMI and complex diabetes and a skin infection

Specialist stroke and neurological rehabilitation

- **The need:** A significant proportion of people who have had a stroke require a period of targeted rehabilitation in an environment with specialised staff and facilities, in line with national stroke guidance.
- **Location:** Specialist stroke care is provided at the Oxfordshire Stroke Rehabilitation Unit (OSRU), located at Abingdon CH
- **Examples of patients supported**:
    - A person who has had a stroke and needs intensive therapy to help them to regain the ability to eat, speak and move themselves. This might include speech therapy, support from a dietitian and therapy to improve movement.
    - A person who needs 2:1 care following a stroke to support them with eating drinking, washing, dressing, toileting and overnight needs. They also may need dietitian and specialist support to feed including starting up Peg feeding and NG tube feeding and support to learn to feed themselves prior to returning home.

- Inpatient care and rehabilitation for those with level 2 neuro-rehabilitation needs (as defined in national guidance) could be co-located with Stroke rehabilitation to enable sharing of specialist resources, facilities and expertise and a more sustainable staffing model

Specialist care at the end of life

- **The need:** Most people prefer to die at home when nearing the end of life and this aim will be supported through enhanced community-based end-of-life-care services and primary care, in partnership with the hospice charities. Much care for people in the last year of life will continue to be provided in Community Hospitals with the aim of restoring their independence and enjoyment of life at home for as long as possible. However, a small number of specialist palliative care beds is necessary to support some people at the end of life when it is not possible to provide them with adequate symptom control at home or when other factors mean an admission is necessary to ensure safety or minimise distress. Not all patients admitted to one of the specialist palliative care beds will die there; some will have a planned return home once stabilised.
- **Location:** Specialist end-of-life care is best provided in a purpose-built facility that provides a calm environment, enables family members to stay on site and where staff can develop specialist skills in palliative care.
- **Examples of patients supported**:
    - A patient with hard-to-manage symptoms for whom a period of in-patient care would be preferable to care at home. The reasons for this can include carer fatigue or distress; the patient lives alone without support between carer visits; there is no suitable hospice placement available
    - A patient who prefers not to live their last days in the family home; the patient may be a parent of young children; there may be symptoms which could be more easily stabilised in an in-patient environment; or they may require additional nursing support or treatment in their last days.

Home first

Home First is the national NHS policy ambition to help older people receive care in their own homes wherever possible. NHS Reducing length of stay guidance describes taking a 'Home First' approach, providing patients with support at home or intermediate care. Wherever possible, patients should also be supported to return to their home for assessment. [7]

A study carried out by the *Better Care Support Programme* (available at reducingdtoc.com) found that on average, 27% (a range of between 19% and 35% across the areas) of the 10,400 individuals studied were declared to be medically fit for discharge yet remained in hospital. When these patients got discharged, in 92% of these cases, the setting was providing a more intense level of care than required to maximise the individual's independence[8]. Based on the data gathered as part of this work, achieving best possible outcomes for people whose discharges had been delayed would mean the number of people:

- returning home with reablement increasing by almost 200%
- going home with support increasing by almost 33%
- discharged into residential or nursing care reducing by almost 50%

It is widely accepted that almost everyone wants to leave hospital as quickly as possible and, usually, to return to the living arrangements they enjoyed prior to their admission with the highest level of

[7] NHS England » Principle 5: Encourage a supported 'Home First' approach
[8] People-first-manage-what-matters.pdf (reducingdtoc.com)

independence, wellbeing and quality of life possible, given the circumstances. Staff caring for people also want them to be discharged to the right place, in the right way, at the right time[9].

A hospital is a good place to be when you are acutely unwell, but it can also bring its own risks. In every hospital admission, there is a risk of picking up an infection. For the more vulnerable, being in hospital can mean:

- losing confidence in the ability to live independently
- losing the continuity of whatever care packages are in place
- losing mobility

In addition, older patients can often experience confusion and disorientation in an unfamiliar environment and daily routine. As a result, the home first approach proposes that where an individual is able to return home safely, they should be supported to do this rather than remaining in a hospital bed.

John Bolton principles

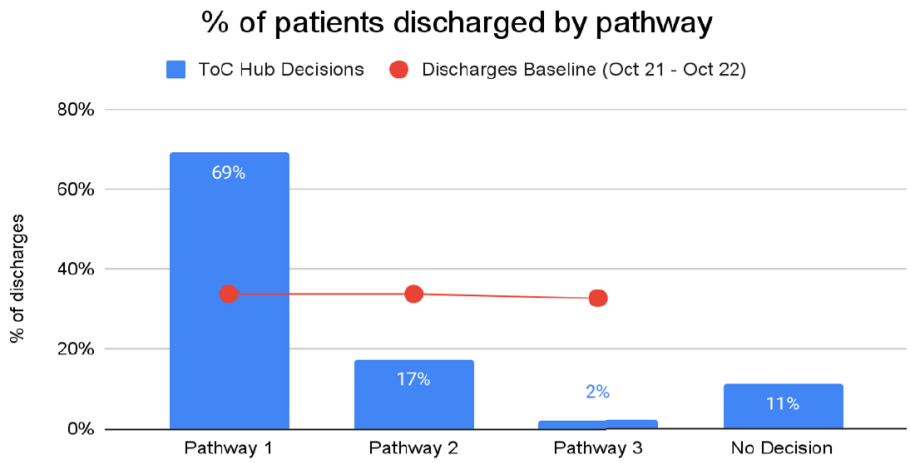
To guide system planning, targets around the aggregated percentages of patients discharged from acute hospital who should be managed through different discharge and reablement pathways have been identified. These were articulated by Professor John Bolton in a review of learning from seven health and care communities between July 2020 and June 2021[10]. This looked to improve their local arrangements on hospital discharge with a focus on the needs of older people.

The pathway targets for acute hospital discharges are:

- Pathway 0 – people discharged home with no additional support needed: 50%
- Pathway 1 – people discharged home with support: 45%
- Pathway 2 – people transferred to a community rehab bed: 4 %
- Pathway 3 – people transferred into long term care (e.g. a care home): 1%

To deliver this change to discharge pathways, we need to move from focusing on inpatient care to care based within the community.

Within Oxfordshire this work is being delivered through the development of the Transfer of Care hub which is focused on ensuring discharges are appropriate and identifying opportunities to support more patient to return home early.



[9] People-first-manage-what-matters.pdf (reducingdtoc.com)

[10] Developing a capacity and demand model for out of hospital care | Local Government Association

Digital opportunities

As healthcare has developed, there are increasing opportunities to use digital technology to provide services differently. A recent pilot within Oxfordshire community services has carried out remote monitoring to inform clinicians about patient need. This has shown that by using technology to enhance visits, clinicians can better meet patient need. There are opportunities through the implementation of more home-based care on a virtual ward to make use of technology such as remote monitoring using apps, technology platforms, wearables and medical devices such as pulse oximeters to help to keep more patients at home and reduce emergency admissions to hospital.

Third sector collaborative working

Within Oxfordshire there is a strong third sector and this has been regularly recognised within previous engagement work. For example, within the OX12 engagement work carried out it was identified that:

> There is a vibrant third sector in OX12 with a wide range of clubs, leisure classes, events, and support services, with many opportunities for volunteering and/or sharing skills, knowledge and interests. There are active health and care groups such as MIND, MS Society, Young Carers, and AGE UK that support people with specific health conditions. A range of online resources to promote health and wellbeing are also available to people living in this community. However, feedback from stakeholders suggests that more could be done to make people aware of these resources.

As part of the implementation of the integrated improvement programme there is an opportunity to better align NHS services with the voluntary and community sector, including consideration of the development of a community hub which could host some of these services. A Community Hub is a multipurpose centre, based at an accessible community site such as community hospital, health centre, day centre or other local facility, that provides the infrastructure to support a range of health and care services – including visiting services, clinics, outpatients, voluntary and community group activities and other services tailored for the needs of the local community. A key feature of the Hub is that it has locally empowered leadership and engagement with its community, with the potential to develop and support new services in response to changing community needs.

Dependencies

Optimal service location modelling

As a part of the wider integrated improvement programme, this work will need to take into consideration the optimal location for all community services across the County. In order to do this, it is recommended that consideration be given to how development of this services model will align with wider services. In order to inform this, it is proposed to use a population health approach to assessing service location and identify how the needs of the population as a whole can best be met.

Outpatients

In addition to the inpatient beds within the community hospitals, there are a variety of other services co-located at the sites. Some host services such as midwifery while others provide outpatient functions, therapy hubs and minor injuries units. Through the provision of outpatient services, the community hospitals are also able to provide preventative care for all ages of patient and to provide care to a much larger part of the population.

In summer 2021, it was agreed to trial a range of outpatient clinics within Wantage community hospital, following discussions with JHOSC and the Town Council Health Subcommittee. The aim is to evaluate the benefits and feasibility of providing additional services to the population of Wantage who would otherwise

have had to travel to Oxford. The pilot services are being provided in the clinical space previously used for the in-patient unit, which has remained closed pending the outcome of the Oxfordshire-wide review of Community Services now underway and public engagement. The interim evaluation report of the pilot can be found at appendix 5. Since that report was published the additional audiology and ENT services have been initiated so that the following outpatient's services are now provided from the hospital:

- Ophthalmology
- Adult Mental HT
- Psychological Therapies
- Adult Eating Disorders
- Talking Space
- GP Health Centre
- Perinatal
- Neuro Development
- NHS Provider audiology
- Ear, Nose & Throat (ENT)
- Connect Health MSK physiotherapy

Urgent care service changes

Within the integrated improvement programme there is another piece of work which is looking at first contact care. This will include decisions around the optimal location for urgent care services within the county. This workstream is not dependent on the outcome of this piece of work, however consideration will be given to where there are opportunities to align decisions with this work.

Next steps

As outlined in this paper, system-leadership and collaborative work will be essential to address the financial sustainability challenge and transform community services so they can deliver the best care possible in a sustainable way.

This work summarised in this document forms part of the Oxfordshire Integrated Improvement Programme and has been led by the Oxfordshire Integrated Leadership Board. It is anticipated that these governance arrangements will continue, to ensure a system position is developed. The Oxfordshire Place-Based Partnership will provide oversight to this work on behalf of the local authorities, local partners and the ICB. enabling key levers (e.g. financial, commissioning) to be used and strengthening public accountability mechanisms for the work.

Subject to any appropriate governance and consultation processes, the following steps are proposed:

- Confirmation of support from system partners (through the above governance) to progress the development work highlighted in this paper on the same-day emergency care, acute virtual ward care and community hospital inpatient care services into a finalised case-for-change proposal
- Engage with the public and other stakeholders to seek views on the proposals and develop specific options for implementation. This includes focused work with local stakeholders to apply the agreed pathways and models to specific local sites, to enable options appraisals to be engaged on and completed. This will enable decisions on the future of Wantage Community Hospital inpatient unit and other services at the hospital to be progressed and finalised.
- Operationalise the recommended options arising from the engagement work into local implementation plans and work with stakeholders to agree resources and timelines for delivery