Joint Health Overview and Scrutiny Committee

Report by Corporate Director for Adult Social Care on Support for People Leaving Hospital

1. This report provides an update to the Committee on the JHOSC recommendations made in January 2024, and the recommendations from Healthwatch Oxfordshire's report on people's experiences of leaving hospital, which was presented to the Committee in November 2025.

Background

2. Over the last few years, the national health policy ambition has been to adopt community and home-based care models outside of acute hospital settings. This involves services such as hospital at home and Integrated Neighbourhood Teams (INTs), which prevent admission to hospital, and, where people are admitted to hospital, helping them to leave hospital quickly, safely and with support tailored to their needs.

3. While patients in hospitals previously required a care needs assessment before returning home, Discharge to Assess (D2A) enables people to return home once they are medically fit. An assessment is completed within 72 hours, which informs a tailored package of care. This model reduces length of stay in hospital and can support a quicker recovery and return to independence. The model is considered best practice by NHS England (2016) and aligns closely with the Oxfordshire Way strategic vision to support people to live independently at home for as long as possible.

Oxfordshire performance update – D2A and supporting people at home

4. Following a successful pilot in July 2023, the D2A service was formally rolled out across Oxfordshire from January 2024. Over the last year, the service has developed significantly:

We are supporting more people to go home from hospital quicker

4.1 Although previously among the worst performing Local Authority areas in the country for hospital discharges in 2017, Oxfordshire is now in the top quartile for discharge performance nationally.

4.2 Oxfordshire's improved performance for discharge has meant we have been better prepared for the winter period. Oxfordshire completed 150 discharges in the week of New Year's Eve and the system declared OPEL 1 – Operational Planning Escalation Level the lowest level of concern – on Boxing Day.

4.3 We are supporting 23% more people to move safely out of hospital compared to last year, completing over 7000 discharges throughout 2024.

4.4 The average length of stay in hospital for people once they are "medically optimised for discharge" and ready to leave has reduced from 8 days to 5, meaning people are spending less time in hospital and more time at home. Where people can go home earlier, the risks of staying in hospital relating to deconditioning and future independence are well-attested.

We are achieving positive outcomes for people following a hospital stay and working to prevent future admissions

4.5 Following discharge, many people receive short-term reablement support to help them re-gain their independence and continue living in their own home. In January 2025, 71% of people on our reablement pathways reached full independence following discharge from hospital. A further 12% of these people experienced a reduction in care needs compared to their assessment. This illustrates that we are providing high quality support in the face of increasing demand.

4.6 An increase in care market capacity to deliver reablement and long-term home care means that fewer people are being discharged to short stay hub beds and directly to permanent care home placements. This has meant Oxfordshire is able safely to reduce the number of short stay hub beds and the Council is now the 16th lowest Local Authority in the country for permanent care home admissions.

4.7 There has also been a 128% increase in referrals from community settings into reablement compared to 2023, meaning we are supporting more people to remain in their own homes, and preventing future hospital admissions.

4.8 Data shows that typically fewer than 10 of the 450-500 people who go home under discharge to assess each month are readmitted to hospital within the 72-hour initial assessment period. In Oxfordshire 86.3% of people in 2023/24 supported through reablement remained at home 91 days after discharge from hospital. This data has been collected annually as part of the Better Care Fund. Generally, national data suggests that where people over the age of 75 have an admission to hospital in the last year of life, 33% have a single admission and 16% have 5 or more admissions. We are reviewing readmission rates from all discharge pathways (D2A, via short stay hub bed or via community hospital bed) as part of Better Care Fund planning for 2025/26. There will be opportunities to increase the resilience of arrangements to support people once they get home e.g. via Integrated Neighbourhood teams.

5. The service has made significant progress in one year. However, this does present several challenges.

a. The amount of activity through the D2A service is now frequently achieving double what had originally been planned per week. This puts financial pressure on the Oxfordshire system in relation to the Additional Discharge Funding, which is used to fund D2A, and particularly the County Council which currently funds the majority of reablement activity.

b. In recognition of the positive impact of D2A detailed already, the Oxfordshire system, via the Joint Commissioning Executive, has committed to continue supporting the current delivery model. However, further discussion on how the system will fund the activity increase is needed.

c. A key focus for this year's Better Care Fund (BCF) planning process was supporting discharge and system flow by reducing non-elective admissions, particularly for people with more complex needs. However, our data shows that non-elective admissions are increasing. Understanding the reasons for this will form a key part in this year's Better Care Fund (BCF) planning process and help us move towards a more sustainable delivery model. This will include more co-ordinated support in the community to avoid readmissions for people who have been supported home.

d. The activity increase is placing significant pressure on organisations and employees. Home First and TOC teams, and staff in our care providers, continue to experience recruitment challenges. This is particularly the case in relation to Occupational Therapist posts that are vital to the effective planning and delivery of D2A. We are working to ensure staff are well-supported. We are also working together as a system to explore creative solutions to recruitment, such as secondments and cross-organisational working.

Progress update on HOSC recommendations in January 2024:

Recommendation from JHOSC January 2024	**Update January 2025**
1. That a process of learning and evaluation is reviewed and developed. It is recommended that input from Healthwatch Oxfordshire and service users is also enabled inasmuch as possible so as to improve the process of learning and evaluation.	The D2A service has developed at pace and has provided rich learning for the Oxfordshire system. The service is continuously adapting and operational learning is shared and developed via fortnightly D2A system review meetings attended by system partners and the care market. Partners also supported Healthwatch Oxfordshire on their recent report on peoples' experiences leaving hospital – see next section.

2. For the establishment of clear KPIs for the purposes of measuring the performance of services delivered under Discharge to Assess and the Oxfordshire Way. It is recommended that there is clear transparency around this, alongside the inclusion of lived experience (including the learnings from the data in the Wantage co-production work) and the evaluation of long-term outcomes.	System performance for D2A and, by extension, the Oxfordshire Way is reported into the monthly Oxfordshire Urgent and Emergency Care (UEC) Board, as part of the Home First Team update and the Oxfordshire sit-rep report. The KPIs for the service align with the Better Care Fund (BCF) metrics around supporting discharge and reducing care home admissions. Per point 8, further work to reduce non-elective admissions will be undertaken as part of this year's BCF planning process. To support the launch of the service last year, members of the Home First team met with councillors and members of the public in Wantage to hear about their lived experience, receive feedback and respond to concerns around D2A. Engagement such as this is ongoing (see below). We have an ambition to develop a D2A feedback form to ensure we regularly receive patient input into how we can improve the service. We will involve patients in the development of the form via patient focus groups. This work will commence in April 2025.
3. For communications and regular public engagement to be adopted so as to provide reassurances to the public as to the quality of the services they could expect to receive upon being discharged from hospital; and for any additional feedback from the public or stakeholders to be heard.	Between June and October 2024, we delivered the Health and Social Care connections programme, which aimed to: - Connect senior leaders with the public - Share information about new services, including D2A - Listen to public experiences - Promote how we are integrating health and care services in Oxfordshire The programme: • **Conducted 10 stakeholder sessions** to raise awareness

	and gather feedback from key stakeholders. • **Held 10 individual sessions** with recent service users in the context of existing workshops and events. • **Participated in 8 large-scale events** including Play Days, to engage with communities through informal settings. • **Hosted 3 online webinars** to reach a broader audience, including stakeholders and the general public. The programme achieved positive senior leadership engagement across the NHS and County Council, successfully shared information about new services and collected valuable feedback from the public. Future sessions will aim to utilise existing networks to support under-represented groups. The programme also identified that more work is needed to increase the public's understanding of the integrated care system and how it supports their experience of health and social care. This work is being delivered via the updated BOB approach to working with people and communities.
4. For patients to be clearly communicated with in relation to the services they will receive upon being discharged from hospital. It is also recommended that leaflets for patients include an outline of the complaints processes in place.	This action was also identified by Healthwatch and formed part of the action plan in our response. A discharge leaflet (see appendix 1) has been developed and is now offered to all patients when admitted to hospital. The leaflet includes: - The possible routes for going home after a hospital stay, and what to expect if more support is needed, including an outline of the Discharge to Assess service and other places of care such as a Short Stay Hub Bed or community hospital - Frequently asked questions - A going home checklist

	- Key contacts and support available for post-discharge support, including Single Point of Access (SPA), Live Well Oxfordshire and Age UK Oxfordshire resources
5. To ensure that staff who provide support for discharged patients at home receive adequate and ongoing training.	This action was also identified by Healthwatch and formed part of the action plan in our response. Home First and TOC have delivered several joint webinars for staff in acute settings, with an ambition to extend these sessions to community partners, including GPs and district nursing teams over the coming months.
6. To ensure that integrated neighbourhood teams are sufficiently resourced and geographically spread in as appropriate a way possible so as to meet demand across both rural and urban areas. It is recommended that any available resources are maximised to meet demand for support at home, and that further funding is sought to support vital local transformation and prevention work in local communities.	We have developed Integrated Neighbourhood teams in the areas of significant deprivation and are now expanding to the next group of deprived areas. We now have eight INT's focussing on adults across Banbury (2), Bicester, Witney, Faringdon, Oxford City (2) and Wantage. The ninth INT is in one Oxford City PCN and is dedicated to children and young people who neurodiversity and complex needs. We are reviewing areas of priority for the further development of INTs across Oxfordshire. We are working with Better Care Fund (BCF) for the ongoing funding for 2025/2026.

System response to the Healthwatch Oxfordshire report on Peoples' experiences of leaving hospital

6. Several system partners inputted into Healthwatch Oxfordshire's report on people's experiences of leaving hospital, which was presented to the Committee in November 2024.

7. Oxfordshire County Council and Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (ICB) responded to the report jointly, and welcomed the feedback provided by people who have been in hospital, their carers, and health and social care staff about their experiences. We were pleased to hear that many people had a positive experience leaving hospital,

and that the majority of people felt safe and happy to be home. Key reasons for this noted in the report include:

- The provision of clear information and professional, person-centred support for people before and after discharge

- Most people felt listened to, respected and were actively involved, along with their carers, in care planning

- People experienced a joined up, coordinated approach to their care, noting particularly the input from charities, primary care, care providers and health and social care professionals.

8. The report also identified several areas to improve. The County Council and ICB worked with Oxford Health and Oxfordshire University Hospitals on how we would address the report findings as a system and created the following action plan:

Recommendation	Objective	Action	Lead	Update January 2025
1. Improve experience of continuity and quality of care for patients	**Proactively identifying opportunities for care and support**	Explore expanding Age UK Oxfordshire support on acute and community wards	**John Pearce,** Commissioning Manager (Prevention) – Oxfordshire County Council	The potential benefits of Age UK Link Workers spending more time in Community Hospitals have been identified. A meeting attended by several stakeholders to discuss further is being arranged.
	Improving care coordination before, during, and following discharge	Test process for following up all complex discharges from one Primary Care Network in South Oxfordshire. Establish the skill set and workforce required to roll this out to all areas within Oxfordshire.	**Lily O' Connor,** Director of Urgent and Emergency Care, BOB Integrated Care Board	We met regularly with one PCN in south Oxfordshire and their care co-ordinators. All complex discharges continue to be followed up post discharge from hospital. The majority are followed up with a phone call, but some require home visits. We are regrouping in February 2025 to check how it has continued and if any further support is required. This is up and running in other areas such as Banbury, Bicester and OX3.

		Improve process on the day of discharge for medication, transport, and communication. Collate complaints, incidents, and findings from health watch review and agree actions.	**Louise Johnson,** Deputy Director of Urgent Care – Oxford University Hospitals and **Tamsin Cater** Transfer of Care Lead – Oxford University Hospitals	Discharge has been identified as a quality priority for OUH for 2025/26. This action is included in OUH's broader action plan. A verbal update will be given at the JHOSC meeting.
	Assuring high quality care post discharge	Address training and monitoring gaps and rostering opportunities with care providers through existing contract and quality management structures	**Sally Steele,** Area Service Manager Hospitals – Oxfordshire County Council	Teams of trainers have been identified and the existing programme of Home First training has recently been updated. This training includes a workbook and accompanying video that must be completed by all providers. We will also conduct face to face training sessions for staff which will commence in March. We are exploring rostering opportunities as part of our contract management approach.
2. Clear communication to patients and unpaid carers	**Clarity on discharge processes and follow up support**	Complete and publish discharge information leaflet for patients in November 2024 and brief ward staff on the contents	**Tamsin Cater,** Transfer of Care Lead – Oxford University Hospitals	The leaflet is complete and is being offered to all patients when admitted to hospital. We are also updating the Live Well Oxfordshire website with the information provided in the leaflet.
3. Improve	**Proactive**	Continue to	**John**	The action plan for the

support for and identification of unpaid carers	**identification of unpaid carers**	work across the Oxfordshire system to deliver on the All-Age Unpaid Carers strategy, including identification programmes and updating IT systems to support staff	**Pearce,** Commissioning Manager (Prevention) – Oxfordshire County Council	All-Age Unpaid Carers strategy is reviewed quarterly as part of the Oxfordshire Carers Strategy Oversight Group. Following a successful pilot in OUH, there is agreement to scale up the development of carers passports, which help identification of unpaid carers. Carers champions are also being utilised to further support identification. We are working with GPs to review SNOMED codes for unpaid carers to ensure they are accurately flagged to primary care professionals.
	Support for unpaid carers	Working with carers leads in acute and community settings to promote existing carers training and awareness for all staff and signpost to Carers Oxfordshire resources	**John Pearce,** Commissioning Manager (Prevention) – Oxfordshire County Council, **Di Hilson,** Carers Lead – Oxford Health, and **Caroline Heason,** Carers Lead – Oxford University Hospitals	Per above action, Oxfordshire system carers leads meet every quarter as part of the Oxfordshire Carers Strategy Oversight Group. Across health and social care we have a wealth of resources and training available to improve staff awareness of the support available for unpaid carers. Carer's leads are working to promote these to staff and signpost to Carers Oxfordshire

4. To continue to develop joined up working across the system	**Improving communication and understanding between services**	Continue to deliver training workshops and webinars with all those involved in the discharge process, expanding to community partners including GPs, district nurses and out of area teams. Work with providers to complete the D2A information leaflet.	**Sally Steele,** Area Service Manager Hospitals Oxfordshire County Council and **Tamsin Cater**, Transfer of Care Lead – Oxford University Hospitals	Per JHOSC recommendation 5, Home First and TOC have delivered several joint webinars for staff in acute settings, with an ambition to extend these sessions to community partners, including GPs and district nursing teams over the coming months.
		Explore opportunities for timely sharing of discharge letters with unpaid carers, GPs and Home First	**Sally Steele,** Area Service Manager Hospitals Oxfordshire County Council and **Tamsin Cater**, Transfer of Care Lead – Oxford University Hospitals	Discharge has been identified as a quality priority for OUH for 2025/26. This action is included in OUH's broader action plan. A verbal update will be given at the JHOSC meeting.

Next steps

9. The progress of the above action plan and JHOSC recommendations is being monitored quarterly through the Urgent Care Delivery Group. We will continue to work as a system to ensure we fulfil the plan and address the JHOSC recommendations.