Delegated Decisions by Cabinet Member for Adult Social Care

Tuesday, 21 January 2025 at 9.00 am
Room 3 - County Hall, New Road, Oxford OX1 1ND

If you wish to view proceedings, please click on this Live Stream Link.
However, that will not allow you to participate in the meeting.

Items for Decision

The items for decision under individual Cabinet Members' delegated powers are listed overleaf, with indicative timings, and the related reports are attached. Decisions taken will become effective at the end of the working day on Tuesday, 28 January unless called in by that date for review by the appropriate Scrutiny Committee.

Copies of the reports are circulated (by e-mail) to all members of the County Council.

These proceedings are open to the public

Martin Reeves
Chief Executive

January 2025

Committee Officer: ***Committee Services***
E-Mail: committeesdemocraticservices@oxfordshire.gov.uk

Note: Date of next meeting: 25 February 2025

If you have any special requirements (such as a large print version of these papers or special access facilities) please contact the officer named on the front page, but please give as much notice as possible before the meeting.

Items for Decision

1. Declarations of Interest

See guidance below.

2. Questions from County Councillors

Any county councillor may, by giving notice to the Proper Officer by 9 am two working days before the meeting, ask a question on any matter in respect of the Cabinet Member's delegated powers.

The number of questions which may be asked by any councillor at any one meeting is limited to two (or one question with notice and a supplementary question at the meeting) and the time for questions will be limited to 30 minutes in total. As with questions at Council, any questions which remain unanswered at the end of this item will receive a written response.

Questions submitted prior to the agenda being despatched are shown below and will be the subject of a response from the appropriate Cabinet Member or such other councillor or officer as is determined by the Cabinet Member, and shall not be the subject of further debate at this meeting. Questions received after the despatch of the agenda, but before the deadline, will be shown on the Schedule of Addenda circulated at the meeting, together with any written response which is available at that time.

3. Petitions and Public Address

Members of the public who wish to speak at this meeting can attend the meeting in person or 'virtually' through an online connection.

Requests to speak must be submitted by no later than 9am four working days before the meeting. Requests to speak should be sent to committeesdemocraticservices@oxfordshire.gov.uk .

If you are speaking 'virtually', you may submit a written statement of your presentation to ensure that if the technology fails, then your views can still be taken into account. A written copy of your statement can be provided no later than 9 am 2 working days before the meeting. Written submissions should be no longer than 1 A4 sheet.

4. Minutes of the Previous Meeting (Pages 1 - 2)

5. Dimensions - Henley. Oxford, Wallingford, Didcot, Abingdon, Banbury lot 1, 2, 4 and 5 contract replacement (Pages 3 - 8)

Cabinet Member: Adult Social Care
Forward Plan Ref: 2024/359
Contact: Jordan Marsh, Commissioning Officer
Jordan.marsh@oxfordshire.gov.uk

Report by Director of Adult Social Care (**CMDASC**).

The Cabinet Member is RECOMMENDED to:

a) **agree to the re-tender of the supported living services currently provided by Dimensions under four separate service contracts – Henley, Oxford, Wallingford, Didcot, Abingdon, Banbury (HOWDAB) lot 1, 2, 4 and 5 ("Current Service Contracts");**

b) **agree to separating the services provided under the Current Service Contracts into two different contracts based on the needs of the people supported ("New Contracts"); and**

c) **delegate the completion of New Contracts to the Director of Adult Social Care following the selection of a provider or providers under the mini-competition process of the Live Well Supported Services Framework Agreement under Lot 1.**

Report by Director of Adult Social Services.

6. Short Stay Hub Beds (Pages 9 - 64)

Cabinet Member: Adult Social Care
Forward Plan Ref: 2024/289
Contact: Ian Bottomley, Lead Commissioner – Age Well
Ian.bottomley@oxfordshire.gov.uk

Report by Director of Adult Social Care (**CMDASC**).

The Cabinet Member is RECOMMENDED to:

a) **approve the procurement and commitment of budget to purchase the new Short Stay Hub Bed (SSHB) model; and**

b) **delegate to the Director of Adult Social Services authority to award call off contracts under the Light Touch Care Homes Framework further to procurement.**

Councillors declaring interests

General duty

You must declare any disclosable pecuniary interests when the meeting reaches the item on the agenda headed 'Declarations of Interest' or as soon as it becomes apparent to you.

What is a disclosable pecuniary interest?

Disclosable pecuniary interests relate to your employment; sponsorship (i.e. payment for expenses incurred by you in carrying out your duties as a councillor or towards your election expenses); contracts; land in the Council's area; licenses for land in the Council's area; corporate tenancies; and securities. These declarations must be

recorded in each councillor's Register of Interests which is publicly available on the Council's website.

Disclosable pecuniary interests that must be declared are not only those of the member her or himself but also those member's spouse, civil partner or person they are living with as husband or wife or as if they were civil partners.

Declaring an interest
Where any matter disclosed in your Register of Interests is being considered at a meeting, you must declare that you have an interest. You should also disclose the nature as well as the existence of the interest. If you have a disclosable pecuniary interest, after having declared it at the meeting you must not participate in discussion or voting on the item and must withdraw from the meeting whilst the matter is discussed.

Members' Code of Conduct and public perception
Even if you do not have a disclosable pecuniary interest in a matter, the Members' Code of Conduct says that a member 'must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself' and that 'you must not place yourself in situations where your honesty and integrity may be questioned'.

Members Code – Other registrable interests
Where a matter arises at a meeting which directly relates to the financial interest or wellbeing of one of your other registerable interests then you must declare an interest. You must not participate in discussion or voting on the item and you must withdraw from the meeting whilst the matter is discussed.

Wellbeing can be described as a condition of contentedness, healthiness and happiness; anything that could be said to affect a person's quality of life, either positively or negatively, is likely to affect their wellbeing.
Other registrable interests include:

a) Any unpaid directorships
b) Any body of which you are a member or are in a position of general control or management and to which you are nominated or appointed by your authority.
c) Any body (i) exercising functions of a public nature (ii) directed to charitable purposes or (iii) one of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union) of which you are a member or in a position of general control or management.

Members Code – Non-registrable interests
Where a matter arises at a meeting which directly relates to your financial interest or wellbeing (and does not fall under disclosable pecuniary interests), or the financial interest or wellbeing of a relative or close associate, you must declare the interest.

Where a matter arises at a meeting which affects your own financial interest or wellbeing, a financial interest or wellbeing of a relative or close associate or a financial interest or

wellbeing of a body included under other registrable interests, then you must declare the interest.

In order to determine whether you can remain in the meeting after disclosing your interest the following test should be applied:
Where a matter affects the financial interest or well-being:

a) to a greater extent than it affects the financial interests of the majority of inhabitants of the ward affected by the decision and;
b) a reasonable member of the public knowing all the facts would believe that it would affect your view of the wider public interest.

You may speak on the matter only if members of the public are also allowed to speak at the meeting. Otherwise you must not take part in any discussion or vote on the matter and must not remain in the room unless you have been granted a dispensation.

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DELEGATED DECISIONS BY CABINET MEMBER FOR ADULT SOCIAL CARE

MINUTES of the meeting held on Tuesday, 17 December 2024 commencing at 9.00 am and finishing at 09.05 am

Present:

Voting Members:	Councillor Tim Bearder – in the Chair
Officers:	Jack Nicholson (Democratic Services Officer) Izzie Rockingham (Commissiong Manager – Improve Enable)

The Cabinet Member considered the matters, reports and recommendations contained or referred to in the agenda for the meeting and decided as set out below. Except as insofar as otherwise specified, the reasons for the decisions are contained in the agenda and reports, copies of which are attached to the signed Minutes.

26 DECLARATIONS OF INTEREST
(Agenda No. 1)

There were none.

27 QUESTIONS FROM COUNTY COUNCILLORS
(Agenda No. 2)

There were none.

28 PETITIONS AND PUBLIC ADDRESS
(Agenda No. 3)

There were none.

29 MINUTES OF THE PREVIOUS MEETING
(Agenda No. 4)

The minutes of the meeting held on 17 September 2024 were approved and signed by the Chair as a correct record.

30 TECHNOLOGY ENABLED CARE
(Agenda No. 5)

The Chair agreed to the recommendations in the report.

RESOLVED to:

a) **approve the proposal to deliver a new Telecare Monitoring and Response Service, by deployment of the Buckinghamshire Framework from April 2025;**

b) **note the changes from the current Telecare Monitoring and Response Service for existing users and the mitigating actions to support this; and**

c) **note the opportunity to develop how the Council uses Technology Enabled Care (TEC) to support our residents to live independently at home as part of this service.**

..... in the Chair

Date of signing .....

Delegated Decision by Cabinet Member for Adult Social Care

21 January 2025

Dimensions – Henley, Oxford, Wallingford, Didcot, Abingdon, Banbury lot 1, 2, 4 and 5 contract replacement

Report by Director of Adult Social Care

RECOMMENDATION

The Cabinet Member is RECOMMENDED to:

a) **agree to the re-tender of the supported living services currently provided by Dimensions under four separate service contracts – Henley, Oxford, Wallingford, Didcot, Abingdon, Banbury (HOWDAB) lot 1, 2, 4 and 5 ("Current Service Contracts");**

b) **agree to separating the services provided under the Current Service Contracts into two different contracts based on the needs of the people supported ("New Contracts"); and**

c) **delegate the completion of New Contracts to the Director of Adult Social Care following the selection of a provider or providers under the mini-competition process of the Live Well Supported Services Framework Agreement under Lot 1.**

Executive Summary

1. A range of supported living contracts exist within the Council to ensure quality of life standards for people whose care and support needs require more specialist services. These contracts enable people to live as independently as possible within Oxfordshire.

2. This paper focuses specifically on the HOWDAB (Henley, Oxford, Wallingford, Didcot, Abingdon, Banbury lot 1, 2, 4 and 5) contract replacement.

Background

3. The start date of the HOWDAB Dimensions contract was 7th September 2020. The end date of the contract is 6th September 2025.

4. There are 102 people supported over 31 properties.

5. There is an option to extend the current contract for a maximum of five years, the recommendation is to not utilise this extension, which will allow for a replacement contract to transform services. The replacement contracts will

include key performance indicators with a focus on quality-of-life outcomes and greater efficiencies for the council.

6. The projected annual value for Contract 1 is £3,041,744 at an hourly rate of £22.94.

7. The projected annual value for Contract 2 is £4,687,742 at an hourly rate of £23.50.

8. There will be 51 people supported within each contract.

Council Priorities & Policies

9. The prevention and relief of homelessness and achievement and maintenance of independent living continues to be a priority for Oxfordshire County Council. These Supported Living contracts contribute to this priority.

10. Accommodation based support services adopt a person-centred and outcomes focused approach to secure and maintain a sustainable housing tenancy with the opportunity to maximise independence and potentially step down / move on as assessed.

Financial Implications

Supported Living Contract Costs

11. Financial assumptions have been made with the supported living contracts in terms of support delivery and existing hours of support individuals require. The supported living contracts are set up with core shared hours and 1 to 1 hours that can increase or decrease dependant on individual needs. Estimates on the level of core hours of support and the 1:1 hours have been predicted from previous spend on existing contracts including input from Social Workers, Brokerage and Commissioning. Care Act assessments will determine the level of support each person requires. Models to determine how to maximise the core support within and between properties (core and cluster) has been developed for each scheme.

Hourly Rates & Uplifts

12. The price will be set based on the Live Well Supported Services Framework (Lot 1), market tested rates of £22.94 for lot 1 and an enhanced rate of £23.50 for lot 1 where needs are more complex (previously supported at key decision for the recommended hourly price range for the framework). These rates will feature within the annual fee review mechanism which considers inflationary changes, changes to National Minimum Wage and the National Living Wage, local market factors in Oxfordshire and affordability.

Comments checked by: Stephen Rowles, Strategic Finance Business Partner – Stephen.Rowles@oxfordshire.gov.uk

Legal Implications

The legal implications section should be completed by a member of the legal service

13. The Council's statutory powers and duties to provide the supported living services which are to be re-tendered are set out at Part III of the National Assistance Act 1948, the National Health Service and Community Care Act 1990 and the Care Act 2014.

14. To comply with procurement law the proposed call-off contracts must be procured in accordance with the award mechanism set out in the Live Well Supported Services (Adults) Framework Agreement. Providers on such framework agreement were themselves selected competitively under the Council's Contract Procedure Rules and the Public Contract Regulations 2015 (as amended).

Comments checked by: Jonathan Pool, Solicitor (Contracts) – Jonathan.Pool@oxfordshire.gov.uk

Staff Implications

15. The current contract/new contracts do not involve services or staff directly provided by the Council. Therefore, there is no impact on the Council's workforce as a result of these recommendations.

16. It is anticipated that the workforce directly connected to the current contracts would transfer across with the new contracts via TUPE, with expectations built into the contracts to work with staff to transform services.

Equality & Inclusion Implications

17. These supported living contracts are designed to meet the specific needs of people with a learning disability, autism, complex health, and physical disabilities. The expectation of care providers is to deliver person centred support which ensures:

    a) Provision of in-county accommodation so people with Care Act needs are not moved away from their networks.
    b) The least restrictive care to support greater independence for people. People are integrated into their local communities, with their individual needs and preference are met.
    c) Their cultural and religious beliefs are supported to be observed, specific dietary requirements.

d) People can become economically sufficient by supporting people to access training, learning, voluntary and employment opportunities.
e) People are supported to have better access to universal services.
f) Competition in the market to support people to have choice in their care provider.

These Supported Living contracts include the requirement for the provider to have an Equalities Policy. Providers are required within the replacement contracts to self-certify that their organisation has an active Equality & Diversity Policy in keeping with the Equality Act 2010 (a requirement under the Live Well Supported Services Adults Framework).

Sustainability Implications

18. At present a Climate/Environmental Policy is not required by providers.

Recruitment

19. Recruitment for care and support mostly attracts a local workforce, therefore limiting the amount of extensive travel time.

Staff Travel

20. These supported living contracts are for existing accommodation-based services. These are static workplaces unlike domiciliary care calls to multiple locations.

21. People living in supported living are unlikely to attend day centres as support is generally provided by the main supported living contract and therefore are less likely to access vehicles which transport people to and from the day services. Instead within the course of supporting someone staff will be required to travel alongside the individual often on public transport both for accessing the community and for travel training where this is part of an individual's support plan.

Staff Training

22. Many of the support providers contracted offer training online so their staff are not having to travel.

Medical & Health Appointments

23. Where possible support staff will work with an individual to access online appointments. If a face-to-face appointment is required then staff will use public transport, unless this is not possible e.g. risks posed to travel.

Shopping

24. Where possible support staff will work with an individual to access their shopping online. Where it is practical to do so they will carry out online shopping for several people to limit the number of deliveries. Where online shopping is not possible staff will endeavour to use public transport unless it is unsafe to do so. This will be embedded into skills training maximising the persons independence long term.

Risk Management

Risks in agreeing this recommendation

25. There are no risks to agreeing this recommendation. This recommendation will allow for a competitive tendering process involving support providers who have obtained a place on the Live Well Supported Services Framework.

Risks in not agreeing this recommendation

26. If this recommendation is not agreed this would not allow for the Council to undertake a competitive tendering process between support providers who have obtained a place on the Live Well Supported Services Framework. Allowing the existing contracts to end without procuring replacement contracts will leave 102 vulnerable adults in shared supported accommodation where they have their own tenancies without support. Not providing adequate support would mean the council were not fulfilling its duties under the Care Act 2014.

Consultations

27. People who use support and family members have been involved in feeding back on quality through quality monitoring processes. The current provider, Quality Improvement Team and Operational Social Work have also had the opportunity to feedback on the existing provision.

Karen Fuller
Corporate Director of Adult Social Care

Contact Officer:

Name – Jordan Marsh
Title – Commissioning Officer, Adult Social Services
Email – jordan.marsh@oxfordshire.gov.uk

ANNEX

Annex 1

Replacement contracts for tender for supported living schemes requiring procurement of support provider.

Number	Title	Description	Contract Length	Hourly rate	Predicted Annual Value
1	Contract 1	**Replacement contract** Learning disability with autism supported living – Lot 1	5-years, plus 5-years extension	£22.94	£3,041,744
2	Contract 2	**Replacement contract** Learning disability with autism supported living – Lot 1 enhanced rate	5-years, plus 5-years extension	£23.50	£4,687,742

21st January 2025

[END]

Delegated Decision by Cabinet Member for Adult Social Care
21 January 2025

Short Stay Hub Beds

Report by Director of Adult Social Care

RECOMMENDATION

The Cabinet Member is RECOMMENDED to:

a) approve the procurement and commitment of budget to purchase the new Short Stay Hub Bed (SSHB) model; and

b) delegate to the Director of Adult Social Services authority to award call off contracts under the Light Touch Care Homes Framework further to procurement.

Executive Summary

1. The Integrated Care Board [ICB] and the Council purchase Short Stay Hub beds [SSHB] in line with NHS Hospital Discharge to Assess policy to support people who cannot be discharged directly home under Home First Discharge to Assess [D2A]. The current beds have been partly procured under the Council's former Pseudo Dynamic Purchasing System and partly delivered by alignment of former intermediate care beds supplied by Order of St John Care Trust [OSJ] from the Oxfordshire Care Partnership [OCP] agreement. Bed numbers have ranged between 90-100 since 2019 in response to operational demands and pressures on the acute hospital.

2. Since the implementation of the Home First D2A programme more people are being supported to go home after a hospital stay. This was discussed in detail in Cabinet in Paper 2024/346 approved on 17/12/2024. The progress of Home First D2A and the impact on the need for and costs of SSHB is discussed at full in that paper at paragraphs 15-23 (pages 31-34 of the public pack) and at Annex 4 to the paper (pages 49-50 of the public pack). See Annex 1.

3. The development of Home First D2A has led to an opportunity to revise the model and the bed capacity within the SSHB pathway. The Council has worked with clinicians and partner organisations across the health and care system to develop a new model focussed on providing a discharge route for people who are not able to go home directly after a hospital stay but do not need medically supervised rehabilitation in a community hospital setting. For the most part the target population for this new model for SSHB will be either people who are very frail and need a further period of assessment and recovery in a bed-based setting before a long-term decision can be made on their onward pathway or people who have resolving delirium and/or complex dementia presentations where it would not be safe for them to go home at the point of discharge. In the current SSHB model 66%

of people go home after a stay in a bed and the Council does not expect that figure to change significantly in the new model. But more people will have the opportunity to go home as the SSHB will be able to accept more frail and complex people who hitherto may have been placed directly in a care home for long-term care directly from hospital.

4. The current SSHB contract expires on 31 March 2025. The Council will deliver the new model by procuring a block call off contract for SSHB under the Care Homes (Light Touch) Framework.

5. The new SSHB model is aligned to the Care Homes (Light Touch) Framework [CHF] which defines the inputs required and price point for different needs across 5 "care bands". It is proposed that 36 Nursing beds are procured under the CHF with a mixture of Nursing Specialist beds at care bands 4 and 5 which manage a level of complexity and intensity seen and expected in this cohort. The contract for the new model will include flexibility to increase beds in times of sustained higher demand and to reduce these or end the contract with notice if no longer required.

6. To support transition and deliver effective procurement the Council will need to vary the existing SSHB contracts to provide cover in the interim until the new model contracts are in place from July 2025.

7. The care model for the revised SSHB has been agreed across the health and care system and endorsed by the Oxfordshire Urgent and Emergency Care Board. The funding for the SSHB comes from the Oxfordshire Better Care Fund and the business case for the model and the procurement has been agreed by both the Director for Adult Social Services in the Adult Social Care Directorate Leadership Team for the Council on 23 December 2024 and the Integrated Care Board (ICB) Executive Management Committee on 13 January 2025 as joint funders of the future contract. This is a system initiative that builds on existing joint commissioning approaches, supports integration between health and social care and will support delivery of the Better Care Fund Plan for the benefit of our population and in partnership with the provider market.

8. The Council's commissioning team has been working with colleagues and system stake holders to develop the model and to prepare for the procurement from February 2025.

Exempt Information

Not applicable.

Background

9. Detail on the history and development of the SSHB model is set out in Paper 2024/346 which was approved by Cabinet on 17 December 2024. This also sets out the impact of Home First D2A and the case to reduce reliance on bed-based discharge pathways from acute hospital. See page 29 ff of the Cabinet public reports pack at Annex 1.

10. The Council and the ICB has a duty to plan and deliver services that will enable timely and effective discharges from the hospitals when the patient is medically

optimised for discharge and no longer requires an acute bed. The Council provides residential care home services pursuant to its powers under section 21 of the National Assistance Act 1948 and the Care Act 2014. The Council purchases short stay hub beds on behalf of the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board pursuant to a delegation of functions under sections 75, 65Z5 and 65Z6 of the National Health Service Act 2006 as amended.

11. Broadly, the expectation of the NHS Hospital Discharge Policy guidance is that assessment of long-term needs should not happen in hospital and that people should be discharged to one of the following pathways:

Pathway 0	Patient returns home with no support or with informal support from a voluntary and community group. The Council commissions the Age UK Urgent Care Community Links service to support that. This may also include people returning to previous care where there has been no change to their needs. The Council commissions Oxfordshire Association of Care Providers to deliver a *Trusted Assessor* intervention to support this return to prior care setting
Pathway 1	Patient returns to usual place of residence with support. The Council commissions Discharge to Assess from within the Live Well at Home Framework to deliver this. It can be short-term assistance, reablement and/or long-term care. It can also include people who can go straight home from hospital but need community therapy services to support their medical rehabilitation needs. Oxford Health is leading on a pilot to divert patients to this homebased intervention rather than be discharged via a community hospital bed
Pathway 2a-reablement	**Patients need assessment and therapeutic support prior to long-term care decision. This can be delivered in a nursing home environment and is what is delivered by the short stay hub beds**
Pathway 2b-rehabilitation	Patients need medically supervised bed-based rehabilitation delivered in a community hospital bed. There may be an option to take more of these people home under Pathway 1 in the future.
Pathway 3-long-term care	Patients need a new long-term care placement normally in residential or nursing home. This does not include people returning to a previous placement. The guidance states very clearly that we should use Pathway 3 only in exceptional circumstances and instead people should go into Pathway 2a for assessment and to maximise recovery.

12. The SSHB deliver pathway 2a. The work of the system Transfer of Care [TOC] Hub has developed a clear distinction between pathway 2a and pathway 2b in most cases where previously these pathways may have been used more interchangeably. SSHB play a key role in reducing waiting times for those individuals that no longer require an acute bed but who are unable to go directly home via D2A.

13. Oxfordshire has sought to drive the change to Home First D2A by proactively shifting to the new model in 2023-24 and 2024-25. In April 2023 there were 82 SSHB in place. The number of beds were reduced initially to support the change and then in response to the impact of the D2A model. SSHB have further been reduced to 56 from 01/12/2024.

14. Data from Oxford University Hospitals NHS FT [OUH] shows:
    a) 90-100 people per day are ready for discharge from hospital at any given time.
    b) Referrals to SSHB has reduced from 82 pcm to 63 in the past 18 months.
    c) Average LOS (Length of Stay) in the current model is 25 days since April 2025.
    d) Average no of people waiting for a SSHB is 20 at any given time.

15. Patients discharged into SSHB in 2024 were audited in full by the TOC hub. It was found that these individuals were not able to return home under D2A but neither did they need alternatively community hospital beds.

16. SSHB are non-permanent care homes beds with nursing. Part of the current SSHB were procured by the Council through the Pseudo Dynamic Purchasing System (DPS) in 2019 for a period of 5 years with the option to extend for 1 year. The Council is within the extension period and the contracts are due to end in March 2025.

17. The SSHB have been commissioned and contract managed by the Council but are funded jointly by the Council and the ICB via the Better Care Fund.

18. The ICB commission a SSHB Hub multidisciplinary team that support admissions, therapy, assessment and discharge planning for people placed in the SSHB. This is provided by OUH with social work input from the Council. The ICB also commissions medical cover from GPs that otherwise support the provider homes and OUH provides gerontology advice and support via the Hub team as indicated. These dedicated inputs have enabled individuals referred to the SSHB to recover back to their “base level” as far as possible and enable most people to go home following an intensive period of bed-based reablement. This model is consistent with the national best practice models for Intermediate Care.

19. The other part of the SSHB bed stock has been provided by OSJ from within the OCP agreement. This was for former “intermediate care beds” that were aligned to the SSHB model when that contract commenced in Nov 2019. The Hub team and GP inputs to the OSJ beds are the same.

20. It has been agreed with OSJ that it would not be able to work into the new SSHB model, and so the Council is in discussions with OSJ to make best use of these beds and to re-purpose these for use to meet long-term needs in line with the Care Homes (Light Touch) Framework. These beds might be purchased by the Council, by the ICB for people qualifying for NHS Continuing Healthcare or by self-funders.

Proposed Model for SSHB

21. Since the introduction of the D2A model individuals with less complex needs are returning home after a hospital admission. Provider and operational staff feedback has confirmed that a greater proportion of more complex people are being referred for the SSHB. Care Homes providing SSHB have been unable to admit people with complex needs where these exceed the scope of the current contract.

22. The people now being referred to SSHB after the introduction of D2A generally have needs that are described in care band 4 under the Care Homes (Light Touch) Framework (Please refer to **Annex 2** for details of the care bands). The current model for SSHB does not cater for these complex needs therefore we need to procure beds that can meet the needs of individuals as described in care band 4.

23. A small number of the people currently considered for SSHB have more complex needs than care band 4. Their needs fall within care band 5. Care band 5 is not described in detail within the Care Homes (Light Touch) Framework Specification, and therefore, the SSHB Service Specification will confirm expectations for this group. People in this group will include those with resolving delirium, challenging behaviour of severity and/or frequency that poses a significant or risk to self, others or property, or multiple wounds which may not respond to treatment, or require complex tracheostomy management. This group will need significant monitoring and management 24/7 and present complexity and intensity in care delivery. In 2024 the Council and the ICB have commissioned some Band 5 beds funded from the Better Care Fund to inform the new model. This has confirmed that local providers can meet these needs, and that some of these people are able to return home after a period of recovery. This step also provides assurance to unpaid carers and family members that a return home is manageable.

24. In the new model the SSHB will be procured under the following care bands as set out in the CHF and the SSHB service specification:

    a) Band 4: Nursing Specialist- A) Complex Physical Needs & B) Complex Mental Health Needs/ Complex Dementia
    b) Band 5: Specialist Plus care A) Physical Needs & B) Needs arising from Mental Health and/or Complex Dementia.

Proposed SSHB capacity

25. The number of beds required in the new model has been derived from reviewing the admissions into the SSHB, the length of stay in the beds and the number of referrals waiting for this service. In developing the model and the bed numbers, officers have taken account of learning from the small trial of beds under care band 5 with an existing provider of SSHB. This has confirmed the specification for the care band 5 beds and confirmed that a longer length of stay may be required for more complex needs.

26. The number of beds to be procured will be 36 with a split between Band 4 and Band 5. The number of beds has been reviewed as part of the Business Case for procurement and by the system Urgent and Emergency Care Board. There are some unknowns and potential challenges in moving to the new model but the Council and ICB view is that the system should move to the new model at this level of capacity for the following reasons

a) The TOC process and the development of Home First D2A (particularly to support people with live-in and nighttime care) will continue to identify people who can be diverted from the SSHB pathway to Home First. Also, the new model will enable some people who would otherwise go directly into long-term care to be diverted to a SSHB
    i. Both features improve outcomes for the individual, reduce lengths of stay in the acute hospital and improve practice and responsiveness across the system, including with independent providers
b) In the new model there will be further opportunity to improve efficiency through partnership working with providers in the way that has been achieved in Home First D2A.
c) In the new model the Hub team support to the beds will move to 7 days increasing throughput through therapy input and timely discharge planning
d) Current lengths of stay in SSHB are extended in some instances owing to sourcing delays for homecare or care home placement. There is scope for the Council to reduce these in partnership with the Hub team and providers: there is ample capacity both within the Live Well at Home Framework and the Care Homes (Light Touch) Framework
e) The contract will have provision to scale up and down the number of beds procured by +/- 50% of the original contracted bed numbers with an upper ceiling of 54 beds. In the case of short-term pressures or shifts in Demand and Capacity planning within the Better Care Fund it would be possible to increase capacity and potential providers of the SSHB will be asked to evidence this as part of the bids.

Approval for Business Case for SSHB

27. The Business Case to proceed with a procurement of 36 SSHB in the new model as a call-off to the Care Homes (Light Touch) Framework was approved by Adult Social Care Leadership Team for the Council on 23/12/2024 and by the ICB Executive Management Committee on 13/1/2025. The funding for the SSHB is shared by both partners within the Better Care Fund. Approval for the Business Case to proceed to procurement of the SSHB is delegated to the Director of Adult Social Care under the Council's scheme of delegation.

28. The Business case set out the key benefits and risks of the SSHB. In summary the model:
    - Works to the national NHS Hospital Discharge Policy guidance and is in line with the national model of Intermediate Care
    - Supports people to get the best possible experience of discharge by reducing length of stay in acute hospital and giving them the best chance of returning home
    - Supports flow from acute hospital and reduces bed occupancy and the risks of readmission
    - Increases capability in our discharge pathways and engages the market of providers registered within the Care Homes (Light Touch) Framework
    - Delivers to a high specification and promotes person-centred, strengths-based care and support
    - Reduces long-term financial exposure by supporting more people away from long-term care home placement, whilst also reducing costs in the acute hospital

29. Within the Business Case the Council and the ICB are asked to commit funding from the Better Care Fund to purchase the new SSHB model. The reduction in SSHB delivers savings within the Better Care Fund which are needed and will be recycled to support the significant increase in Home First D2A as well as more "upstream" services that support independence, hospital avoidance and the Oxfordshire Way. These savings will be reallocated as part of the Better Care Fund plan for 2025/26.

30. The funding within the Better Care Fund required to purchase the new SSHB model is as follows:

Full year budget based on potential fee uplifts				
	3% uplift	4% uplift	5% uplift	6% uplift
OCC	£715,300	£722,200	£729,200	£739,600
ICB	£2,352,100	£2,375,000	£2,397,800	£2,432,100
Total	**£3,067,400**	**£3,097,200**	**£3,127,000**	**£3,171,700**

a) The SSHB will be purchased using the Light Touch Care Home Framework banding for Band 4 beds and a set figure for Band 5 beds. The Framework now represents an understood and agreed currency between the Council and the marketplace and effectively matches the price paid to the needs of the individual. In the procurement the Council will stipulate the fee and will seek to evaluate the bids on quality and ability to deliver the model.
b) The final budget will be subject to the agreed fee uplift applied to Light Touch Care Homes Framework bandings in 2025/26. The Council is currently seeking views from providers on its proposals and so budgets across the likely range is set out here.
c) For the Council, the purchase of 36 SSHB in the new model will cost between £715,300 and £739,600 per annum subject to the final agreed uplift.
d) For the Council to proceed with the procurement, the ICB needs to confirm its commitment of the required budget. This was confirmed by the ICB Executive Management Committee on 13 January 2025.

31. The new contract will be issued for a period of 3 years with an option to extend by up to 2 years. After procurement, the new contracts will come into effect 1 July 2025.
a) This timeline creates a potential gap in provision as the current SSHB contract terminates on 31/3/2025. To support an effective and safe transition to the new model for patients, providers and staff the Council will extend the current SSHB contracts exceptionally for 3 months from April-June 2025 in line with Contract Procedure Rules.
b) The negotiations with OSJ re the repurposing of their current SSHB will be aligned to this timetable

32. The providers and the location of the beds under the new SSHB contract cannot be confirmed until the outcome of the procurement. Broadly the Council will seek to source beds in the north, city and the south to reflect both the population and the flow out of Horton General, John Radcliffe and Royal Berkshire Hospitals respectively.

33. As set out above at paragraph 26e, the contract will have provision to increase or reduce the number of SSHB in line with demand. The council and the ICB have agreed in the business case that
    a) Any increase to the number of SSHB which exceeds the budget set out in paragraph 31 will need to be funded additionally from the health and care system whether within the Better Care Fund or from some other source.
    b) The need for any increase will be determined by demand and capacity planning and reviews within the Better Care Fund plan, and be agreed by the wider system at Urgent and Emergency Care Board
    c) Any proposals to increase the number of beds will need to
        i. identify additional budget to fund them. Identification of resource would be identified with the Urgent and Emergency Care Board and agreed by the Council-ICB Joint Commissioning Executive which is accountable to Cabinet and the ICB Board for budgets, and to the Health & Wellbeing Board for delivery of the Better Care Fund plan
        ii. be confirmed by the Director of Adult Social Services, the Director of Law & Governance and Monitoring Officer and s151 Officer
        iii. be managed in accordance with the Council's rules and procedures and may need a new decision

Corporate Policies and Priorities

34. The procurement aligns with the following strategic priorities identified in the Council's Corporate Plan:
    a) **Tackle inequalities in Oxfordshire.** With the adoption of a care bandings approach based on need the Council has improved its ability to address assessed care needs and support more vulnerable people home from hospital
    b) **Prioritise the health and wellbeing of residents**. The SSHB model will map the needs of patients within the hospital to the D2A pathways so that the right care is delivered at the right time. The SSHB model will provide patients with the best opportunity to optimise their health and where appropriate return home.
    c) **Support carers and the social care system**. The SSHB model supports the care needs of the individuals that require this level of the care outside of the hospital and when it is not possible to return home under Home First D2A model. The SSHB model integrated across health and social care in partnership with the provider market will improve response to needs and develop the care inputs to meet those needs.
    d) **Work with local businesses and partners for environmental, economic and social benefit.** The SSHB model will be delivered by the Care Homes (Light Touch) Framework and support the business development model of local care home providers.

Financial Implications

35. This will be funded from Better Care Fund managed within the Age Well pooled budget under the financial responsibility of both the council and the ICB. Any increase to this contract will be managed in line with affordability and agreement from both parties.

    These beds will feature as part of our annual fee review mechanism which considers inflationary changes, changes to the National Living Wage and other local market factors in Oxfordshire.

Comments checked by:

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Legal Implications

36. The Council provides residential care home services pursuant to its powers under section 21 of the National Assistance Act 1948 and the Care Act 2014. The Council purchases short stay hub beds on behalf of the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board pursuant to a delegation of functions under sections 75, 65Z5 and 65Z6 of the National Health Service Act 2006 as amended.

37. The proposed call-off for short stay hub beds will be undertaken in accordance with the call-off procedures set out in the Care Homes (Light Touch) Framework which was established in accordance with the Public Contracts Regulations 2015.

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Staff Implications

38. There are no direct staffing implications for the Council other than the planned expansion of the HESC Brokerage and Quality Improvement teams resourced by the ICB.

Equality & Inclusion Implications

39. The SSHB model supports some of the most vulnerable patients in acute hospital beds to be discharged to an appropriate setting in which they may recover and be able to return home. This reduces the risk of elderly and sometimes disabled people being placed directly from hospital into restrictive long-term care
40. As part of the procurement bidders will be asked to set out how they will meet the protected characteristics of people likely to be discharged to these beds and support the user and their family.

Sustainability Implications

41. The proposed SSHB model does not directly create any sustainability benefits or issues. As part of the evaluation of bids the Council will assess providers commitment to and plans to move to a carbon neutral model for their businesses.
42. The OUH Hub team will be embedded in the SSHB sites, and a reduced number of beds and sites will reduce the need for staff to operate in a peripatetic model, and so should reduce journeys.

Risk Management

43. This is a complex area of service development and there are several key risks that have been highlighted above and addressed in the Business Case.

44. These risks include:

a) Risk of failed procurement. This is not likely: there is strong interest in the new SSHB model which will be procured using the fixed prices attached to care bands and using the care banding models and definitions that were developed with the marketplace. The Council anticipates a successful procurement.

b) Medical and therapy/support to the model: the medical model is being developed by the ICB in partnership with local GPs and the Hub team and will be in place to support the new SSHB contract. The SSHB Hub team will continue and will move to 7-day working.

c) Impact of a reduced number of beds. The business case has modelled efficiency opportunities from reducing delays at the "back door" of SSHB, and the impact of 7-day support and continued diversion from bed pathways for people who can go home. These are intended to maintain the flow out of hospital and address the risk of SSHB availability significantly affecting the acute hospital position. Discharges to SSHB currently represent about 8% of "supported discharges" where people cannot go home unaided. If the flow into SSHB reduced that could result in an increase of 1-2 additional people delayed in hospital each day. The Council believes that the new model will be able to manage this, but the contract will include provision to scale up beds in the event of sustained or short-term increased demand.

d) A reduced number of beds and sites might increase the risk of "blocked" capacity for instance in the event of a flu outbreak. This is already an issue that has to be managed by the OUH SSHB Hub team in partnership with the Council commissioners. The proposed reduction does not significantly alter this risk which is mitigated by normal business processes.

e) There have been public concerns regarding the siting of SSHB to support local populations and especially carers. In broad terms the beds will be procured to provide a north-city-south profile that reflects flow out of local hospital sites. The beds will have to be on public transport routes. The beds are specialist, and the final location will be the result of rigorous quality-checking and assurance of bids to provide the beds.

f) The current SSHB provided by OSJ will not proceed into the new model after agreement that they cannot deliver to the new specification. This creates a risk to the Council and to OSJ. The Council and OSJ are working to repurpose these beds for long-term care aligned to the Care Homes (Light Touch) Framework and this will be delivered against the same timetable as the procurement.

g) The SSHB are jointly funded by the Council and the ICB from the Better Care Fund. There are significant pressures on the Fund relating mainly to costs associated with the expansion of Home First D2A. The reduction in the number SSHB allows the Council and the ICB to move resources to Home First D2A and to other "upstream" preventative models.

Consultations

45. There is no requirement on the Council to consult in this instance. The development of the new SSHB has been extensively discussed with system partners and Care Homes (Light Touch) Framework providers and has been

endorsed as a model. The paper approved by Cabinet on 17/12/2024 emphasised the engagement that has been and will continue to be undertaken around moving to a Home First D2A model and more broadly supporting people in their own bed, rather than any other one. There will be engagement with stakeholders as part of a communications plan, including around the repurposing of the OSJ beds.

Karen Fuller
Corporate Director of Adult Social Care

Annex 1 Cabinet report 2024/346

Annex 2 - CHF Agreement including Care Bands

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13 January 2025.

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CABINET
– 17 December 2024

Henley Short Stay Hub Beds

Report by Director of Adult Social Services

RECOMMENDATION

1. **The Cabinet is RECOMMENDED to**

   (a) Note the history of step-down bed provision in Oxfordshire and to endorse the Home First Discharge to Assess model of care that has been implemented countywide since January 2024
   (b) Note the impact of Home First Discharge to Assess for users, hospital flow and on business efficiency across the County and in the South Oxfordshire area
   (c) Agree that the former Chiltern Court beds are not reinstated for the reasons set out in the paper
   (d) Note the decision of the Secretary of State for Heath not to "call in" the decision to close the Chiltern Court beds
   (e) Note the engagement that has taken place with the public and stakeholders during 2024
   (f) Endorse ongoing engagement with Oxfordshire residents around out of hospital care

Executive Summary

2. This report addresses the Motion agreed by the Council on 5/11/2024 and questions subsequently raised by Councillor Gawrysiak addressed to Cabinet (see Annexes 1 and 2). It sets out the background to the decisions made in 2023 and the actions taken subsequently to address the concerns raised in the Motion.

3. The decisions and actions set out below form part of a transformational shift to support more people live in their own homes in their own communities. The Council and NHS and other partners have made a series of strategic changes to how the health and care system supports residents in Oxfordshire in line with

   (a) best clinical practice of out of hospital care
   (b) national policy directives
   (c) most efficient use of the Oxfordshire pound
   (d) support for our residents in line with the ambitions set out in the Oxfordshire Way.

4. The Council and partners acknowledge the concern set out in the Motion and elsewhere that it did not engage residents and stakeholders in Henley sufficiently prior to the decisions made in 2023. This report sets out the engagement that has been undertaken to share our vision and seek views in relation to out of hospital care and the Oxfordshire Way during 2024.

5. Since Council agreed the motion at (2) the Secretary of State has responded in full to Councillor Gawrysiak's request to "call in" the decision to close the short stay hub beds in Henley. This letter is attached as Annex 3. This confirms the expectations of the NHS in respect of consultation on changes to health services but states that the closure of the beds at Chiltern Court, Henley does not meet the threshold for intervention.

6. The Council is currently developing the replacement model for step down beds on expiry of current contracts. Subject to the agreement of the business case for that new model by the Council and Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB) as joint funders, the integrated commissioning team will procure replacement services in 2025.

7. In response to the Motion of 5/11/2024 the report

   (a) Sets out why the Chiltern Court beds need not – and therefore should not – be reinstated
   (b) Confirms the engagement approach that the Council and partners have taken and will take going forward, but also confirms that there are no plans for formal consultation on the closure of beds at Chiltern Court

Short Stay Hub Beds

8. "Short-stay hub beds" are a local Oxfordshire initiative to support discharge from hospital where someone cannot directly go home. The model was developed in 2015-16 in response to extreme winter pressures when there was insufficient reablement and homecare to help people go directly home but where there was capacity in the care home market. There is no statutory requirement on a Council or local NHS system to maintain "step-down" beds to support flow from hospital and where there are alternatives to a bed-based pathway. It is now national policy that these opportunities should be prioritised and maximised.

9. In Oxfordshire there has been a heavy reliance on step down beds which grew significantly in the period 2015-2019, and then again in response to the Covid pandemic in 2021-2023. During the earlier period Oxfordshire was often the worst-performing system in the country for delayed transfer of care with as many as 200 people unable to move on from hospital when medically fit to do so.

10. The numbers of beds, the type of beds and support model into those beds developed over time in response to immediate system pressures (see Annex 4). The Chiltern Court beds in Henley were contracted by the Council at the request of the then Oxfordshire Clinical Commissioning Group (OCCG) in November 2016.

11. This mix of bed types and contracts created confusion in discharge practices; created as many delays as it solved; and had a level of risk in relation to outcomes arising from the range of in-reach support models. Overall, this "portfolio" of step-down bed models did not reduce days lost to delay in the acute hospital and it risked pushing patients towards long-term residential or home care.

12. In 2019 the Oxfordshire health and care system agreed that the model of step-down beds needed to be rationalised and streamlined as part of system demand and capacity planning led by the then Accident & Emergency Delivery Board in response to the ongoing poor performance in relation to delayed transfers of care. It was agreed that the Council would:

    (a) Commission on behalf of the system 56 short stay hub beds on the open market against a revised specification focussed on supporting people on a pathway home
    (b) Align the 41 intermediate care beds contracted from Order of St John Care Trust [OSJ] within the Oxfordshire Care Partnership Agreement [OCP] to the new short stay hub specification

13. It was agreed that the funding for the beds would be pooled and shared pro-rata between the Council, OCCG and Oxford University Hospitals FT [OUH] and that the support into the beds would be provided by the multidisciplinary Hub team hosted by OUH.

14. The number of beds in the system continued to flex up and down. During the Covid pandemic there was a requirement to develop an additional covid-secure pathway ("Designated beds") and ongoing pressures on the system meant that the Council purchased additional winter interim beds in 2021/22 and 2022/23. See Annex 4 for more information.

The development and impact of Home First Discharge to Assess

15. In response to the Covid pandemic in March 2020 the NHS "cleared the hospitals" to create emergency capacity. This approach was then written into the Hospital Discharge Guidance published in August 2020 and frequently updated Hospital discharge service guidance - GOV.UK

16. In summary the guidance sets out that

    (a) Hospital is an inappropriate and potentially risky place for people who do not have a medical need to be in an acute bed
    (b) Assessment of people's long-term needs should take place away from the acute wards, and be focused on strengths rather than deficits if the discharge is to support recovery towards maximum possible independence
    (c) When people are discharged home reablement ensure that they recover full independence in 65% of cases and reduced care needs as part of a reablement approach in most cases

(d) 95% of people leaving hospital should be discharged home, with or without support

17. The figure of 95% has become a target in the Better Care Fund metrics and has replaced the old "delayed transfers of care" metric.

18. Oxfordshire has created several roles and reshaped structures to support the implementation of the Guidance:

(a) A Home First lead, jointly funded from the Better Care Fund and hosted by the Council was created in 2022 to lead on Discharge to Assess [D2A] and improve practice with care providers;
(b) Transfer of Care [TOC] team was set up by the system in January 2023 to manage discharges and allocate resources to support flow
(c) A jointly funded TOC manager was established for April 2023 and the team expanded from managing OUH discharges to Oxfordshire patients in other hospitals (e.g. Royal Berkshire Hospital-RBH) in August 2023.

19. In spite of these developments, Oxfordshire did not make significant progress towards the 95% metric in 2021/22 and 2022/23. The system Urgent and Emergency Care [UEC] Board resolved to address this problem as a key part of the Oxfordshire Better Care Fund for 2023/24 by the following actions:

(a) Move to a D2A model to take people directly home from hospital by default. The Council:
    (1) Piloted a D2A model in July-December 2023 with Strategic Partners within the Council's Live Well at Home [LWAH] Reablement and Home Care Framework and achieved proof of concept. The model was implemented county-wide in January 2024.
    (2) Extended the LWAH service to include additional live-in and waking nights care. This meant the TOC team could divert people home who might previously have been discharged to a bed. These changes ensured that reablement could be delivered safely and effectively and offered assurance to residents and their families about going home.
    (3) Reorganised the former Hospital Social Work teams in winter 2023/24 to support the "pull" model to help people home from hospital
(b) Reduce the number of short stay hub beds as capacity to take people home increased. The number of beds was reduced from 94 in March 2023 to 63 in April 2024. This reduction included the 7 beds at Chiltern Court.

20. In 2024/25 the Better Care Fund Plan has further extended this model
(a) The system invested Additional Discharge Funding in an expansion of live-in and waking night support to D2A and reablement
(b) The Home First manager has developed a Trusted Assessor model with LWAH framework providers which has increased efficiency in the pathway by removing assessment delays

(c) The Council has increased the number of providers working within the D2A and reablement pathway

(d) The number of people discharged home has increased weekly by on average 30% from 2023/24

(e) The Council has significantly increased the amount of reablement being delivered in the community since Jan 2024 to avoid admissions to hospital. The monthly number of new starts in the community has increased from 18-90 over this period.

(f) The D2A model has:

  (1) Enabled people who might previously waited for reablement to go home, find their feet and return to independence with a brief intervention from LWAH providers

  (2) Avoided people being stuck in hospital awaiting a long-term home care package

  (3) Continued to support >70% of people to full independence after reablement and a further 15% to a reduced care package

  (4) Not seen an increase in readmission rates from the D2A process- of 392 D2A discharges in September 2024 only 12 were readmitted to hospital

  (5) Information on the performance of D2A is set out in Annex 5 for Oxfordshire as a whole and for South Oxfordshire specifically

(g) Overall, the Oxfordshire focus on co-ordination of discharge processes and on strengths-based assessment and D2A approaches has contributed to:

  (1) A reduction in bed days lost to delay from 3796 in January 24 to 3105 in October, a reduction of 18%

  (2) A reduction in average waiting time in the Home First pathway of 1.5 days per patient from Sep 23 to Oct 24

  (3) A reduction in average waiting time for people awaiting a Community Hospital or Short Stay Hub bed of 3.5 days per patient

  (4) and an overall reduction in bed occupancy in Oxford University Hospital sites from 96.54% in Nov 2023 to 94.10% in Oct 2024. This increases the capacity of OUH to manage Emergency Department pressures, and also reduce the risk of cancellation of planned procedures.

21. There remains work to be done. Generally, the system needs to stop people coming into hospital and there are a range of initiatives funded by Better Care Fund and ICB urgent care funding to support that approach which are under review by the UEC Board. There is a risk that D2A becomes a victim of its own success if it creates space in acute beds that are "filled behind them". This is recognised by UEC Board as a system risk.

22. The increased level of activity also creates financial challenges for the Council and the Integrated Care Board within the Better Care Fund which will need to be considered in the Better Care Fund Plan for 2025/26. But overall, the cost of looking after people at home is much more efficient:

(a) The costs of taking someone home for reablement is £***1174*** per episode; if on assessment at home they do not need reablement the cost is £250

(b) Where people go home with D2A and reablement the overwhelming majority end up with no or reduced ongoing home care needs. This represents a significant cost avoidance for the Council compared with the costs of larger care packages direct from a hospital bed. It is also better for the person who has the maximum opportunity to regain as much of their independence as possible

(c) By contrast the average cost of a Short Stay Hub bed is (2024/25 rates) is £1500 a week, plus the cost of the Hub team and medical cover. There are some people who do benefit from bed-based assessment and reablement, but this pathway should only be used when consistent with the patient's needs on discharge from hospital

23. The experience of people and professionals of D2A has been the subject of a recent Healthwatch Oxfordshire report which can be accessed at People's experiences of leaving hospital in Oxfordshire – a report summary - Healthwatch Oxfordshire. The report details both good practice and challenges around-especially-communication to people in the discharge pathways, involvement of unpaid carers, join up between hospital and community teams when people are discharged, and general information around discharge pathways. The Council and partners have developed an action plan which will be reviewed in the system Urgent Care Delivery Group [UCDG] and the Carers Strategy working group. A new discharge information leaflet is now being finalised as part of the response. The report did not identify any significant levels of concern around D2A as opposed to bed-based pathways and provided positive statements regarding the level of quality of care being delivered into people's own homes.

Questions raised by Councillor Gawrysiak

24. Councillor Gawrysiak has raised specific questions further to the Motion agreed by Council on 05/11/2024:

(a) **Were the Chiltern Court beds NHS beds?**
The Chiltern Court beds were contracted by the Council from OSJ on behalf of OCCG in November 2016 as a variation to the OCP agreement. The funds to pay for the beds were pooled between the Council and OCCG as part of the then s75 NHS Act 2006 agreement. The beds were treated as part of the system discharge capacity as set out in Annex 4. These were jointly commissioned and funded beds contracted by the Council. They were not "NHS beds".

In her response to Councillor Gawrysiak, the Minister of State confirms that, *"a service being funded from the BCF does not impact duties on NHS commissioners or local authorities to involve patients and the public, through engagement or consultation";* but also, that, *"as local joint commissioners, the NHS BOB ICB and OCC are best placed to determine the needs of their local population".*

(b) **To remove them needs a consultation?**
The Minister of State has confirmed that, *"the Secretary of State has decided that this does not meet the threshold for intervention",* and notes

that the view of the Joint Health Overview Scrutiny Committee at its meeting on 16 January 2024 that this was not a material change needing consultation.

That said, the Director of Adult Social Care and the ICB Director of Place have both acknowledged that there could and should have been greater engagement to communicate the changes and that has been reflected in later work. See paragraph 25 below

(c) **Full and transparent Data from RG9 Henley, RG4 Sonning Common, RG 8 Goring Woodcote, OX 9 Thames, OX 49 Watlington, HP18 Chinnor and OX 10 Wallingford of discharge paths for patients?**

See Appendix 5. In broad terms, demand and delivery for D2A and step-down beds is consistent in these post codes as with the rest of the County. Outcomes for people from these postcodes is also consistent.

It should be noted that people in post codes in the north and south-west of the District Council are more likely to have been admitted to the John Radcliffe site and then discharged to City or South Oxfordshire sites should they need Short Stay Hub beds.

(d) **Beds are being provided at Burcot which is 17 miles by car away. We have no bus service from Henley so that is not an option. How can it be justified that Geography was not taken into account such that there is no provision in South Oxfordshire to serve a population of 140,000 residents?**

It is acknowledged that the journey by public transport is difficult to the Short Stay Hub bed site in Burcot for Henley residents. As noted above the same is true in reverse for perhaps the majority of South Oxfordshire residents who by contrast can reach the City or Burcot.

It is important to note that the District Council area is not a planning unit for step-down beds. These beds are specialist and will be more so in the new model (see below paragraph 26ff). The Council will seek to ensure a geographical spread and accessibility in the upcoming procurement but that will be subject to location of suitable bids.

(e) **What is the RBH view on this and its impact on delayed discharges?**

See Annex 5. RBH has confirmed that the number of people discharged into bed-based pathways has reduced by on average 1 patient per month since April 24. There have been no referrals for short stay hub beds since March.

RBH has fed back that the TOC team “decides pathways very quickly. Our Hospital Discharge Team speak well of the new TOC process and have good working relationships with them. There are daily updates and twice weekly opportunities for wards to discuss cases”.

RBH does however flag that "Patients and relatives often do not understand the rationale of patients with relatively high needs going home with D2A and this can cause an amount of anxiety. A patient information leaflet [referenced above, para 23] has been developed with Oxford TOC colleagues"

This feedback is entirely consistent with the experiences in OUH across the implementation of the TOC and Home First D2A model.

Data on RBH discharges is supplied in Annex 5. Broadly the number of discharges has remain the same each month across 2023 and 2024 to date, with an increase of people going home under D2A.

In terms of length of stay, the waits for D2A have broadly reduced on average and those for step down beds have remained largely the same

25. As noted at paragraph (24b) the Council and the ICB has recognised that there was insufficient communication and engagement re the changes at Chiltern Court. Further it is acknowledged that the transformation to home-based out of hospital care needed to be shared and discussed with residents and stakeholders in Oxfordshire. This was the conclusion of HOSC in January 2024 (drawing a comparison with the work with local people in Wantage around planned changes to the use of the Community Hospital site) and led to the Healthwatch Oxfordshire report discussed at paragraph 23. A series of engagement roadshows has been undertaken during 2024 to promote understanding and debate around these crucial changes to the way we support our vulnerable population.

Next steps for step down beds

26. The Short Stay Hub bed contracts issued in November 2019 have been extended but come to an end in March 2025.

27. A business case is in development for the future provision of step-down beds. The new model will change and be focussed on:

(a) People with complex nursing needs who might otherwise be considered for long-term residential care on discharge from hospital. The aim of the beds would be to allow those people for whom there is not a safe, sustainable home-first option the opportunity to settle, recover and be assessed in an environment which maximises their independence. Some of these people may then return home with support, some may need long-term nursing care, but the needs and costs may have reduced delivering the least restrictive care for the individual and the most efficient long-term care for Council, the NHS via Continuing healthcare or indeed the individual if self-funding.

(b) People with dementia and/or delirium presentations where a spell of specialist support (possibly with access to a Registered Mental Health Nurse) will enable clinicians to work with the user and their family to

identify the most appropriate onward pathway. This group do badly in acute bed settings but in a pilot that has been running since July 2024 some people have been able to return home once their delirium has resolved. These beds will address a key gap in Oxfordshire's discharge offer.

28. The new beds will continue to be supported by the Hub and the ICB is working with local GPs to develop an appropriate medical cover model.

29. The procurement will be subject to approval of a business case by both the Council and the ICB as joint funders. The new beds will be procured from within the Council's Care Home Framework from January 2025.

30. Views have been sought from past users and carers of short stay hub beds, but feedback to date has been limited. The Council will seek further input from stakeholders before the business case is finalised and communicate any changes to current provision as part of the ongoing engagement regarding the out of hospital care model.

31. The procurement will be via the Council's Care Home Framework. As noted above the location of the beds that are procured will be subject to the quality of bids. The Council will seek to make the beds accessible to carers and family members across the County, but the increasingly specialist provision may limit scope to reflect the County's geography.

Recommendations

32. Cabinet is asked to:
    (a) Note the history of step-down bed provision in Oxfordshire and to endorse the Home First Discharge to Assess model of care that has been implemented countywide since January 2024
    (b) Note the impact of Home First Discharge to Assess from a user outcome, system performance and business efficiency point of view both across the Council and in the South Oxfordshire area
    (c) Agree that the former Chiltern Court beds are not reinstated for the reasons set out in the paper

33. Cabinet is asked to:
    (a) Note the decision of the Secretary of State for Heath not to "call in" the decision to close the Chiltern Court beds
    (b) Note the engagement that has taken place with the public and stakeholders during 2024 and to endorse ongoing engagement with Oxfordshire residents around out of hospital home first care

Corporate Policies and Priorities

34. Supporting people home from hospital and in their own community supports the delivery of
    (a) Priority 3: supporting the health and wellbeing of residents and

(b) Priority 4: support carers and the social care system

Financial Implications

35. **There are no financial implications directly linked to this paper.**
Comments checked by:

Stephen Rowles, Strategic Finance Business partner, Stephen.rowles@oxfordshire.gov.uk

Legal Implications

36. There is no specific requirement for the local authority to conduct a formal consultation regarding these bed closures. Formal consultation is only required where there is a statutory requirement, or a legitimate expectation to do so has been identified. Clearly, the more serious or significant the impact of any proposed changes are, the more likely the views of those affected should be sought.

37. In this instance, it has been observed that the Joint Health Overview Scrutiny Committee determined on 16 January 2024 that this was not a material change needing consultation and as noted above by the Minister '*local joint commissioners, … are best placed to determine the needs of their local population'.* The report identifies however that there has been engagement with stakeholders regarding the proposals and, despite there being no specific requirement for consultation, there is an ongoing commitment to engagement with stakeholders and interested parties.

Comments checked by:

Janice White
Head of Law and Legal Business Partner, ASC and Litigation
Janice.White@oxfordshire.gov.uk

Staff Implications

38. None. There are no direct staffing implications for the Council.

Equality & Inclusion Implications

39. The Short Stay Hub beds are designed to meet the needs of the individuals whose needs are too complex to return home under D2A programme. These are mostly people over the age of 65. This gap is filled by these step-down beds. In the new model the individuals' needs are set out clearly and emphasis is drawn on personalised care in line with care bandings and inputs set out in the

Council's Care Home Framework. Particular emphasis is given to the providers understanding of the impact of health conditions and being able to deliver care for people living with dementia and other health conditions. Short-stay hub beds address the needs of some of our most vulnerable elderly residents.

Sustainability Implications

40. The Short Stay Hub bed model does not directly create any sustainability benefits or issues. As part of the evaluation of bids the Council will assess providers commitment to and plans to move to a carbon neutral model for their businesses.

Risk Management

41. There are plans for procurement of the Short Stay Hub Beds under a new model to meet the needs of those individuals whose needs are too complex, and where they are unable to return home under the D2A programme. The aim is to run this model covering City, South and North parts of the county however the priority is to procure a high-quality standard of beds that can meet this level of complexity and intensity. This coupled with a reduction in the bed numbers in the procurement means there may not be beds available in each part of the County. This has not been the case so far and people who use this service will be informed of this at the outset to manage expectations and to work with any exceptional circumstances.

Consultations

42. As set out at paragraphs 24 and 25 there is no requirement for consultation, but the Council and the ICB have engaged subsequent to the decision to close beds in Henley and have and will continue to engage people around the Home First model.

NAME [Member of SLT]	Karen Fuller, Director of Social Care
Annex:	Annex 1- Motion of the Council dated 05/11/2004 Annex 2-supplementary questions to Cabinet from Councillor Gawyrsiak Annex 3-Letter from Minister of State for Health Annex 4-History of step-down bed provision Annex 5-Datapack
Background papers:	None other than referenced in the report

Contact Officer: Ian Bottomley Lead Commissioner for Age Well 07532 132975 ian.bottomley@oxfordshire.gov.uk

December 2024

Cabinet 17 December 2024
Henley Short Stay Hub beds
Appendix 1-Motion Agreed by Council 05/11/2024

1. Council agreed the following motion by Councillor at its meeting on 05/11/2024

a) In December Oxfordshire County Council removed seven beds from the Chiltern care home without any consultation with the GP's, Henley Town Council or the community of South Oxfordshire. This lack of consultation by the Council is unacceptable and must not be repeated.

b) These beds were originally provided as 'NHS beds'.

c) Following FOI requests to the Integrated Care Board Buckinghamshire Oxfordshire Berkshire West (ICB BOB) and the Council, it has been established that these beds are NHS beds funded by the ICB, this Council and the Oxford Health NHS Foundation Trust. They should not therefore have been closed without full and proper public consultation.

d) Dr Broughton interim Chief Executive of the ICB BOB states 28th February 2024 : "The beds have not 'lost NHS funding', "The beds continued to be overseen by the Oxford University Hospital Hub team."

e) These beds are therefore NHS beds which cannot be removed without consultation.

f) This Council:

1. Deplores the beds' removal without said consultation.

2. Believes that a full and objective account as to why these beds, which serve a population of 140,000 of South Oxfordshire, were removed and what replacement measures have since been taken.

g) This Council requests that Cabinet:

3. Asks partners to seek to account for the reasons why the seven Chiltern Court Beds serving South Oxfordshire cannot be reinstated, bearing in mind the new measures that have since been in place and, in the absence of such an account, take steps to reinstate them.

4. Conduct all necessary public consultations

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Cabinet 17 December 2024
Henley Short Stay Hub beds
Appendix 2-Questions raised by Councillor Gawysriak to Cabinet further to the Motion Agreed by Council 5/11/2024

Q1 A clear statement that these 7 Chiltern Court Beds were NHS?

Q1a I repeat this question one because this has NOT been addressed. These Beds are NHS therefore warrant a consultation for removal.

Q1a To remove them needs a consultation?

It is irrelevant that OCC held the contract because they were being contracted on behalf of Oxford Health and the NHS, they still warrant a consultation. This question was avoided by HOSC.

Q2 Full and transparent Data from RG9 Henley, RG4 Sonning Common, RG 8 Goring Woodcote, OX 9 Thames, OX 49 Watlington, HP18 Chinnor and OX 10 Wallingford of discharge paths for patients?

There are in many patients who cannot be discharged home because they are on their own or have frail relatives who cannot look after them. It has been stated that **zero patients** -who fall into this category -were discharged in the whole of Oxfordshire. I find this unbelievable OR the data is not being captured.

Q3 Beds are being provided at Burcot which is 17 miles by car away. We have no bus service from Henley so that is not an option. How can it be justified that Geography was not taken into account such that there is no provision in South Oxfordshire to serve a population of 140,000 residents?

Provision should be made in the south of South Oxon with an explanation of journey times for relatives and friends visiting.

Q4 What is the RBH view on this and its impact on delayed discharges?

Please recognise that the Chiltern Beds serve Henley, Thame, Wallingford and all their surrounding villages. They also serve communities in Berkshire covered by the Royal Berkshire Hospital.
I have highlighted the relevant passages of the motion.

BUT I again repeat Q1 which has not been answered by OCC, cabinet and ICB BOB.
These beds were and are NHS beds- statement of fact- therefore cannot be removed.

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Department of Health & Social Care

Karin Smyth MP
Minister of State for Health (Secondary Care)

39 Victoria Street
London
SW1H 0EU

06/11/2024

Dear Freddie van Mierlo MP,

Thank you for your letter of 22 July 2024, asking the Secretary of State to use the powers under Schedule 10A of the National Health Service Act 2006 to call in the decision by the NHS Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board (BOB ICB) and Oxfordshire County Council (OCC) to close seven step-down beds at Chiltern Court Care Home.

Summary of your request
You requested that the closure of seven step-down beds at Chiltern Court Care Home be called in because you have concerns with the process that has been followed by the NHS BOB ICB and OCC, specifically a lack of public engagement and consultation on the closure of the beds.

Ministerial intervention powers
The Department has published statutory guidance on the call-in powers in Reconfiguring NHS services - ministerial intervention powers, which sets out how call-in requests may be considered. As explained in the statutory guidance, it is likely that a reconfiguration will not be called in before:

- NHS commissioning bodies and local authorities have taken all reasonable steps to try to resolve any issues; and
- those making a request, or others have tried to resolve any concerns through their local NHS commissioning body or have raised concerns with their local Health Overview and Scrutiny Committee.

To inform a decision on whether to call in a proposal, ministers may consider whether the proposed change meets at least one of the following criteria:

- there are concerns with the process that has been followed by the NHS commissioning body or NHS provider; or
- a decision has been made and there are concerns that a proposal is not in the best interests of the health service in the area.

In addition, ministers may consider:

- whether the reconfiguration proposal is considered to be substantial; or
- the regional or national significance of an NHS service reconfiguration and the impact on the quality, safety, or effectiveness of services.

Secretary of State's decision
Your letter and all of the available information has been considered as set out in the statutory guidance, alongside other available information listed below. On balance, the Secretary of State has decided that this does not meet the threshold for intervention.

Key information considered includes:

- Information provided with John Howell's call-in request
- Minutes of Oxfordshire Joint Health Overview & Scrutiny Committee, Tuesday, 16 January 2024
- Information provided to the Department by NHS BOB ICB
- The Oxfordshire Health and Well-Being Board Better Care Fund plan for 2023-2025

I understand that the ICB discussed the issue with Oxfordshire Joint Health Overview & Scrutiny Committee (JHOSC) on 16 January 2024 and that the JHOSC did not consider it a substantial change. I note that this has been raised with the county council and ICB. I would continue to encourage you to engage with BOB ICB on the aims of the Better Care Fund and provision of out of hospital support in south Oxfordshire.

While we appreciate how patients and the public may feel about the decision, we do not consider this change in particular to be a regionally or nationally significant NHS reconfiguration within the meaning of the guidance.

I would like to clarify that a service being funded from the BCF does not impact duties on NHS commissioners or local authorities to involve patients and the public, through engagement or consultation. I understand that the ICB and LA have, as joint commissioners, agreed approach to hospital discharge which involves less demand for step down beds. This change also supports Home First Discharge to Assess for people who are admitted to hospital, which is a key objective in their 2023-25 BCF plan, by increasing the number of people going home from hospital.

Turning to your concerns about the framework for pooled funding and whether it impacts public consultation, it may be helpful if I explain some background to the BCF. The BCF provides ICBs and local authorities with a framework to make joint plans and pool budgets for the purposes of delivering better joined-up care. The plans produced are signed off by Health and Wellbeing Boards (HWBs). These plans are then assured by NHS England with LGA input and oversight from DHSC and MHCLG. Local authorities and ICBs can voluntarily pool funds into the BCF year-on-year.

The 2023-2025 BCF policy framework includes four national conditions:

- Plans to be jointly agreed by ICBs and local authorities;
- Maintain NHS spend on adult social care in line with BCF growth and invest in NHS-commissioned out of hospital services;
- Implementing BCF policy objective 1: enabling people to stay well, safe and independent at home for longer;

- Implementing BCF policy objective 2: providing the right care in the right place at the right time.

Local authorities and ICBs must make sure that they have placed the funding into a section 75 agreement – a legal agreement for pooling health and social care funding. They will also have to report on actual spend and confirm that the conditions of the BCF have been met at the end of the financial year. This provides assurance that the money has been spent in line with the BCF policy.

As part of the BCF planning and assurance process, local areas and ICBs must agree a plan for their HWB area. BCF partners will need to submit a narrative plan and a planning template, providing details of expenditure from BCF funding sources, capacity and demand as well as ambitions and delivery plans for BCF metrics. BCF plans will be assured and moderated regionally, as well as calibrated across regions. Plans are put forward for approval by NHSE in consultation with DHSC and MHCLG.

The Secretary of State's view is that as local joint commissioners, the NHS BOB ICB and OCC are best placed to determine the needs of their local population. Further, I understand that Oxfordshire's Joint Health Overview and Scrutiny Committee (JHOSC) has also made recommendations to support the communication of this change and for the development of an evaluation to learn from the process of this change overall.

As set out in the guidance, it is important that integrated care systems operate with a high degree of autonomy in making decisions in the interests of their populations. However, we also expect the ICB and JHOSC to continue to work together particularly in regard to the recommendations made by the JHOSC.

Kind regards,

KARIN SMYTH
MINISTER OF STATE FOR HEALTH

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Cabinet 17 December 2024
Henley Short Stay Beds
Annex 4: development and profile of step-down beds over time

1. The short stay hub model developed as follows

Date	Type of bed	No.	Contract and funding route	Support provision
Pre 2010	intermediate care bed (ICB)	20	Council-Order of St John Care Trust [OSJ] Funding initially from OCC and then the Better Care Fund pooled budget	Therapy support from Oxford Health NHS FT [OH]; social work from Council
2010	ICB	14	Council-OSJ Funding from the Better care Fund pooled budget	Therapy from OH; social work from Council
2015-16	Short stay Hub beds	varied	Oxford University Hospitals NHS FT [OUH]-care homes Funding from OUH	Discharge liaison and therapy from OUH; social work from Council- in Hub team
2016	ICB (Chiltern Court)	7	Council-OSJ Funding from the Better Care Fund pooled budget	Therapy from OH; social work from Council
2016	Step up beds (Chiltern Court)	4	Council-OSJ Funding from the CCG	Therapy from OH; social work from Council
2017 onwards	Interim beds	varied	Council-care homes Funding from the Council	Social work from council
2018 onwards	Mitigation beds (lack of reablement capacity)	varied	Council-care homes on behalf of OUH Funded from Council-OUH contract underspends	Hub team

2. In winter 2015/16 in response to system pressures Oxford University Hospital NHS FT began to buy short stay hub beds to ease pressure in the wards and maintain flow in Emergency Departments at the John Radcliffe and Horton General sites. The beds were called “Hub” beds as they were supported by a multidisciplinary Hub team comprising OUH nursing and therapy staff and Council social workers
3. The success of the Hub model in creating capacity in the acute hospital meant that some of the beds were extended and the Hub team was established and funded by the then Oxfordshire Clinical Commissioning Group

4. In November 2016 the Council was asked by OCCG to contract for 11 beds in Chiltern Court, Henley from OSJ. 7 of these beds were intermediate care beds for step-down from hospital and 4 were "step up beds" for short term preventative admissions for people seen in the Henley Rapid Assessment and Care Unit based at Townlands Hospital.
5. From time-to-time further step-down beds were purchased additionally to support flow such that by 2019 there were
   (a) 67 Hub beds contracted directly by OUH
   (b) 41 intermediate care beds contracted from OSJ by the Council within the OCP agreement
   (c) 16 interim beds contracted by the Council to step down people assumed to need long-term residential care
   (d) 21 "mitigation" beds to reflect the challenges facing the then reablement service
      (1) And these beds were variously supported by the Hub team; by Council teams alone; some with therapy support from OHt; some with additional cover purchased from local GP practices; some within the core GP business
   (e) This mix created confusion in discharge practices; created as many delays as it solved; and presented some risk in relation to outcomes arising from the range of in-reach support models
   (f) In 2019 the system agreed that Oxfordshire would move to one model of short stay hub beds supported by the Hub team and with OCCG commissioned additional medical cover. The Council procured 56 short stay hub beds from the local market against a revised specification and aligned the 41 OSJ intermediate care beds to this model.
      (1) The new specification sought to prioritise reablement for people who had the potential to go home and assessment for people needing long-term care (including funded by NHS Continuing Healthcare)
      (2) The funding for the short stay hub beds would now be all within the Better Care Fund within the s75 NHS Act 2006 agreement between the Clinical Commissioning Group and the Council
      (3) The funding for the Hub team was also from the Better Care Fund; the funding for medical cover was directly paid by the Clinical Commissioning Group to local GP practices
   (g) The 4 step up beds at Chiltern Court, Henley were closed in 2019 after an engagement exercise with the local population on the grounds of lack of use. The funding released supported the development of end-of-life palliative care provision.
6. Notwithstanding the intentions of partners, the number of beds continued to flex
   (a) In response to Covid pandemic dedicated covid secure beds were commissioned in 2020-21 (20) and 2021-22 (14)
   (b) The Council continued additionally to purchase "winter beds" on an interim basis in the winters of 2021-22 and 2022-23
   (c) The Short Stay Hub bed contract has provisions for increasing beds, and this was actioned from time to time

7. By March 2023 there were 94 step-down beds in operation. Some beds had been closed in August 2022 but this reduction had been offset by the winter 2022-23 Covid beds and expansion elsewhere in line with the contract.

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Cabinet 17-12-2024 Henley Short Stay Hub Beds Annex 5

- Slide 2-OUH discharge profile South Oxfordshire postcodes
- Slide 3- OUH admissions to Short Stay Hub Beds South Oxon postcodes
- Slides 4 and 5-RBH discharge profile Oxfordshire patients
- Slides 6 and 7-Oxfordshire demand and assessment outcome profile for D2A
- Slides 8 and 9-South Oxfordshire demand and assessment outcome profile for D2A
- Slides 10 and 11-year on reablement demand, delivery and outcomes

Data supplied by OUH TOC team; RBH Discharge team; OCC Home First Team

OXFORDSHIRE COUNTY COUNCIL

Oxford University Hospitals: total discharges April 2023-Sep 2024 South Oxfordshire postcodes

Number of OUH Discharges (Age 65+)	Pathway				
Month	0	1	2	3	Grand Total
Apr-23	109	9	21	14	153
May-23	111	15	20	7	153
Jun-23	105	17	14	13	149
Jul-23	113	10	16	9	148
Aug-23	122	22	16	11	171
Sep-23	110	15	11	13	149
Oct-23	109	23	14	13	159
Nov-23	131	19	22	12	184
Dec-23	131	20	13	15	179
Jan-24	130	22	18	12	182
Feb-24	114	15	10	11	150
Mar-24	151	18	22	11	202
Apr-24	110	23	9	10	152
May-24	122	18	18	9	167
Jun-24	122	13	13	7	155
Jul-24	137	11	13	11	172
Aug-24	125	21	11	7	164
Sep-24	103	18	17	13	151

Pathway 0 = home unaided
Pathway 1 = home with support (D2A since Jan 2024)
Pathway 2 = home via a bed-based pathway (Community Hospital or Short Stay Hub Bed)
Pathway 3 = permanent residential or nursing home placements

The total number of discharges is higher in the winter period to March 24. The numbers discharged overall and by pathway have fluctuated with overall an increase in people discharged home in the 9 months from Jan 2024, and a reduction discharged to beds in P2 or P3 in the same period compared with the 9 months before.

Data from Oxford University Hospitals NHS FT

Oxford University Hospitals: admissions to Short Stay Hub Beds from South Oxon postcodes

SSHB Admissions	SSHB_Name						
Month	Albany (Oxford)	Chilterns Court (Henley)	Henry Cornish (Chipping	Isis House (City)	St Lukes (City)	The Close (Burcot)	Grand Total
Apr-23		6		1		4	11
May-23	3	6		1		5	15
Jun-23		5			1	4	10
Jul-23	1	4		3	1		9
Aug-23	2	4					6
Sep-23		[redacted]		1	2	3	6
Oct-23		[redacted]		2		4	6
Nov-23	2	[redacted]		1		3	6
Dec-23		[redacted]		1		1	2
Jan-24		[redacted]		6		2	8
Feb-24	1	[redacted]	1	2		1	5
Mar-24	[redacted]	[redacted]			[redacted]	4	4
Apr-24	[redacted]	[redacted]		1	[redacted]		1
May-24	[redacted]	[redacted]			[redacted]	1	1
Jun-24	[redacted]	[redacted]		1	[redacted]	2	3
Jul-24	[redacted]	[redacted]		2	[redacted]	3	5
Sep-24	[redacted]	[redacted]	1	3	[redacted]	3	7
Grand Total	**19**	**67**	**6**	**38**	**8**	**66**	**204**

Data from Oxford University Hospitals NHS FT

Since the introduction of D2A from Jan 2024 the number of SSHB referrals for people from South Oxfordshire has halved from 71 in 9 months to 34 in 9 months

Chilterns Court closed to new admissions Sep 23; Albany March 24 and St Lukes April 24

Royal Berks Discharges to Oxfordshire 2023-24

RBFT to Oxfordshire Discharge Volume by Pathway 2023													RBFT to Oxfordshire Discharge Volume by Pathway 2024										
Pathway 0	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-2
Oxfordshire SS	2	1	0	2	0	3	0	1	2	1	4	2	3	1	4		3	4	1	3	4	3		
Oxford Home First											1						1							
CHC					1									1				1			1	1		
self-funder																								
Total volume /month	2	1	0	2	1	3	0	1	2	1	5	2	3	2	4	0	4	5	1	3	5	4		

Pathway 1	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-2
Oxford Home First	12	13	15	15	10	9	11	19	12	20	17	13	10	24	7									
Oxford DTA															4	16	16	9	17	8	11	23		
Oxford Community	9	10	2	2	1	4	1	2	1	3	1	2	2					1	1	3	1	3		
Oxford SS	2	0	3	1	4	3	1	0	0	0	6	0	18	7	5	5	2	1	4	6	7	4		
Self Funder					2		1				1	1							1	1				
Total volume /month	23	23	20	18	17	16	14	21	13	23	25	16	30	31	16	21	18	11	23	18	19	30		

Pathway 2	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-2
Oxford Community	8	9	8	7	14	9	8	5	9	4	6	6	7	4	3	6	7	9	8	7	3	9		
Oxford Hub bed	1	2	0	1	0	1	0	4	1	2	1	1	2	1	1									
SS DTA bed	0	3	1	0	0	0	0	0	0	0	1	1												
Self-funder	1	0	0	0	0	0	0	1	0	0	0	0												
Total volume /month	10	14	9	8	14	10	8	10	10	6	8	8	9	5	4	6	7	9	8	7	3	9		

Pathway3	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-2
Oxford SS	0	0	1	1	3	0	2	1	0	1	1	2	0	1	1	0	0	0	2	1	0	2		
Self Funder	1	1	1	0	1	0	1	1	0	1	1	4	0	1	3	0	1	0	1	3	1	0		
Total volume /month	1	1	2	1	4	0	3	2	0	2	2	6	0	2	4	0	1	0	3	4	1	2		

No patients have been discharged from RBH to a Short Stay Hub bed since March 2024.

Data from Royal Berkshire Hospitals NHS FT

Royal Berks Discharges to Oxfordshire 2023-24-length of stay to discharge (days from referral)

RBFT to Oxfordshire Discharge Average LOW by Pathway 2024

Pathway 0	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Oxfordshire	2	3		2	0	2.6		1	4	2	2.7	6	3.3	3	0.75		2	2.5	0	0	0.75	2.3		
Oxford Home First											1						1							
CHC					0																			
														1				2			1	0		
AVE LOW to DC all	2	3		2	0	2.6		1	4	2	2.6	6	3.3	2	0.75		1.6	2.2	0	0	0.8	1.75		

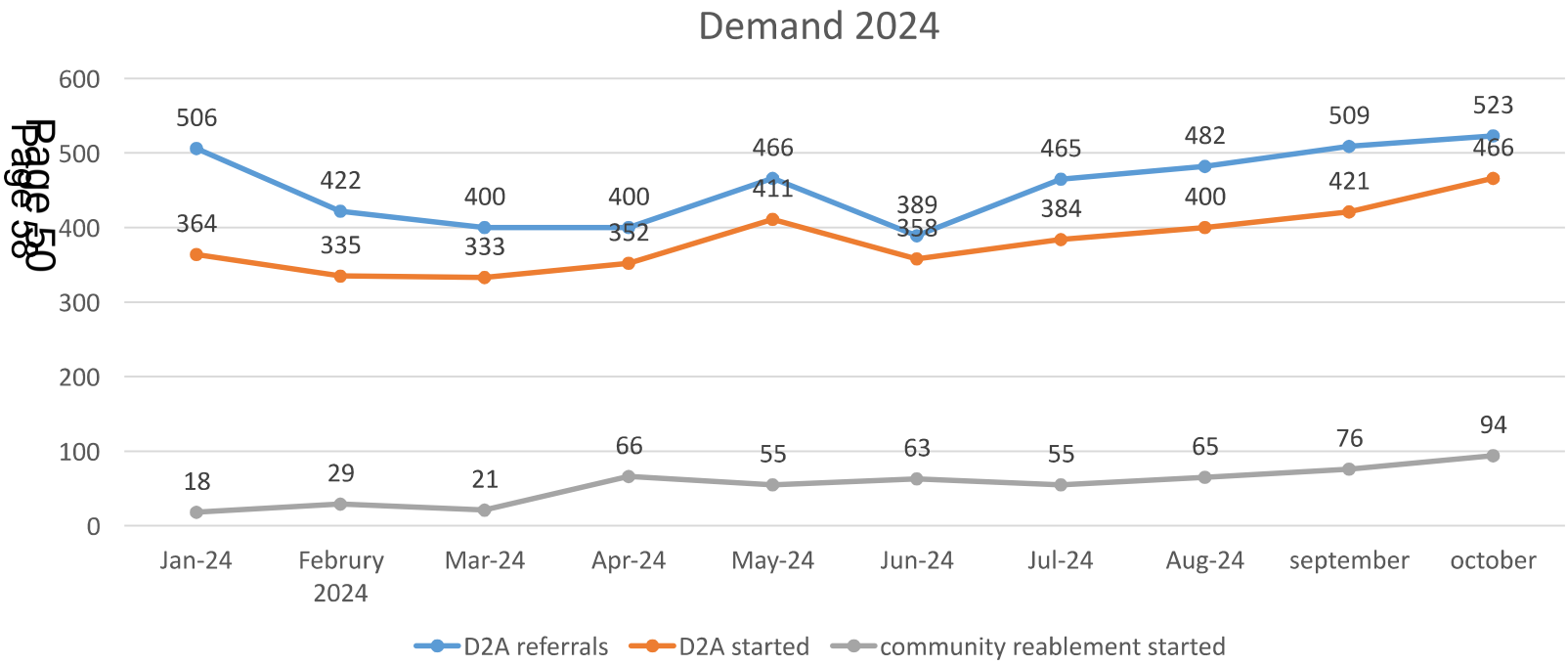
Pathway 1	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Oxford Home First	12	3.8	8.2	4.6	3.3	3.6	4	4.3	4.9	3.9	3	4.5	2.6	2.5	2.4									
Oxford DTA															6.25	4.3	4.8	7.8	8	3.6	4.2	4.9		
Oxford Community	0.3	1.8	0	0	0	0	2	14	32	4	0	5	1.5					0	2	0.3	0	0		
Oxford SS	3.5		9.3	2	4.5	7	4				6.6													
Self Funder					17.5		7				5	10		16					8	56				
AVE LOW to DC all	4.4	3	7.6	4	5	3.3	4	5.2	7	3.9	3.8	4.9	4.8	3.8	4.9	4	4.3	8.6	7	4	4.2	3.8		

Pathway 2	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Oxford Community	7.5	5	3.5	6.1	3.7	4.2	6	2.8	5.2	5	4.3	8.6	8.4	11.5	5	6.3	6.1	5.3	8.5	3.8	5.3	5.2		
Oxford Hub bed	3	9		1		1		4	1	2	1	1	10.5	5	10									
SS DTA bed		9.6	9								15	4												
Self-funder	11							3																
AVE LOW to DC all	7.4	6.5	4.1	5.7	3.7	4.5	6	3.7	5	5.2	5.6	7.5	8.8	10.4	6.2	6.3	6.1	5.3	8.5	3.8	5.3	5.2		

Pathway 3	Jan-23	Feb-24	Mar-25	Apr-26	May-27	Jun-28	Jul-29	Aug-30	Sep-31	Oct-32	Nov-33	Dec-34	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Oxford SS			25	23	4.3		11	16		34	15	22		28	9				46	20		24		
Self Funder	12	7	24		17		2	2		3	12	9.2		18	6		9		8	8.3	0			
AVE LOW to DC all	12	7	24.4	23	15		11	9		18.5	13.5	13.5		23	6.7		9		33	11.5	0	24		

Data from Royal Berkshire Hospitals NHS FT

Demand for D2A and Reablement-Oxfordshire

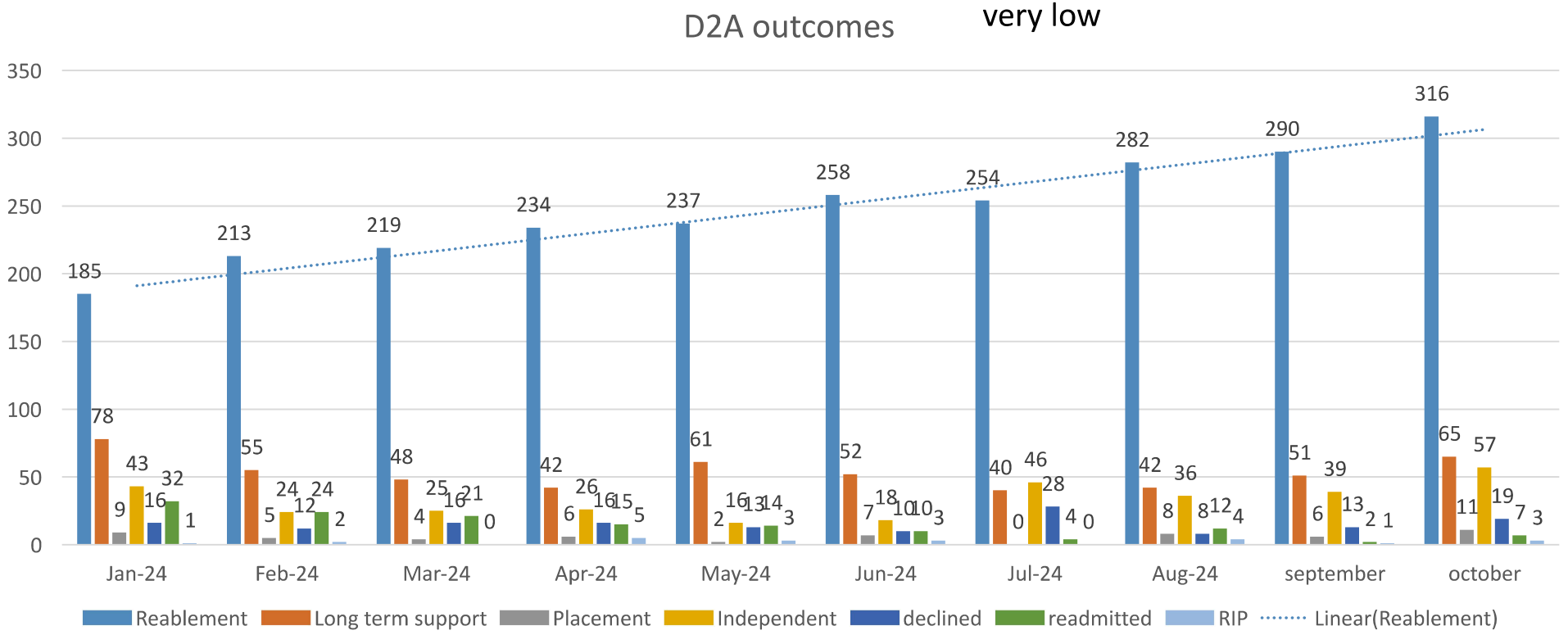


The number of referrals to D2A and the number of people discharged have increased since Feb 2024. Activity in Oct and Nov 24 shows a further increase. Community pick-ups have increased, and we need to shift capacity further to avoid admissions to hospital.

Data from Oxfordshire County Council Home First team

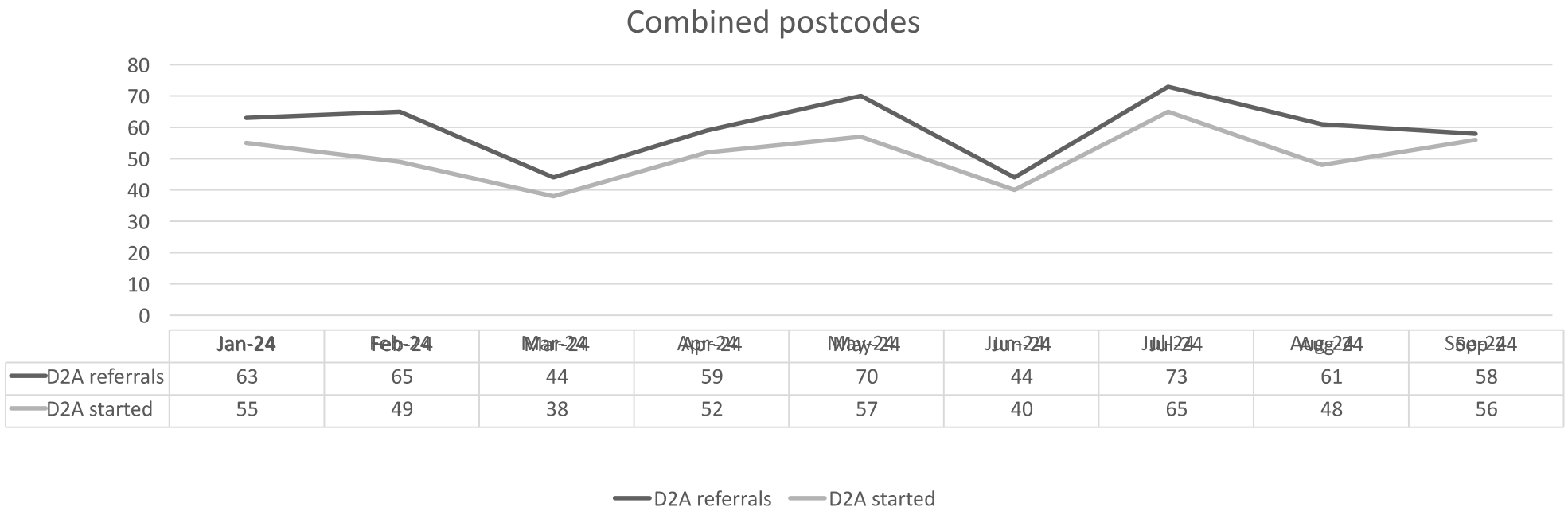
D2A Outcomes-Oxfordshire

This graph shows the outcome of D2A after the person has been home for 72h. Most people proceed into reablement but a significant proportion are already independent. People needing long-term care might previously had an extended wait in hospital. Readmission rates are very low



D2A totals for **RG9, RG8, RG4, OX9, OX10 OX39 & OX49**
Referred for and started D2A

This data is broadly consistent with the position for the rest of the County and in fact shows a smaller gap between referrals and pick-up. This indicates a better rate of response

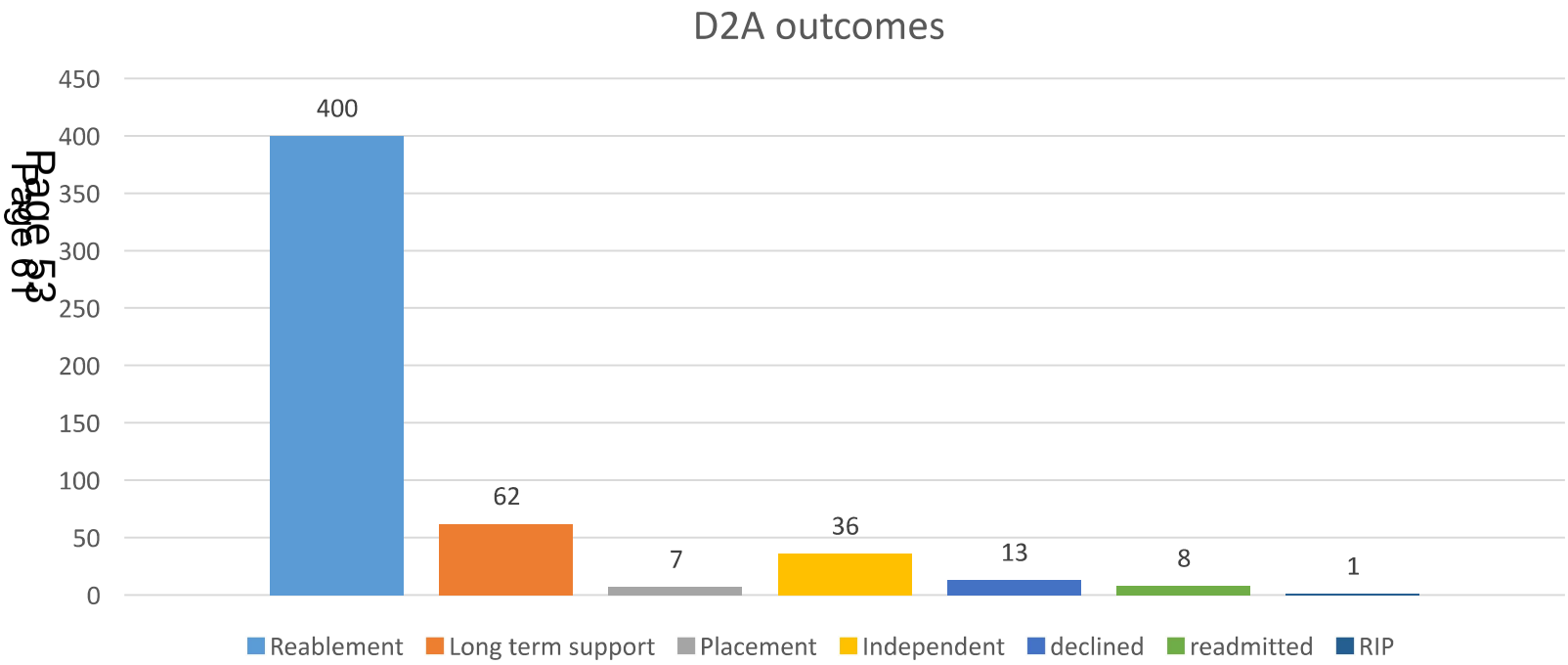


	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
D2A referrals	63	65	44	59	70	44	73	61	58
D2A started	55	49	38	52	57	40	65	48	56

Data from Oxfordshire County Council Home First team

D2A Outcomes January to September 2024

RG9 Henley, RG4 Sonning Common, RG 8 Goring Woodcote, OX9 Thame, OX49 Watlington, OX10 Wallingford, OX39 Chinnor.

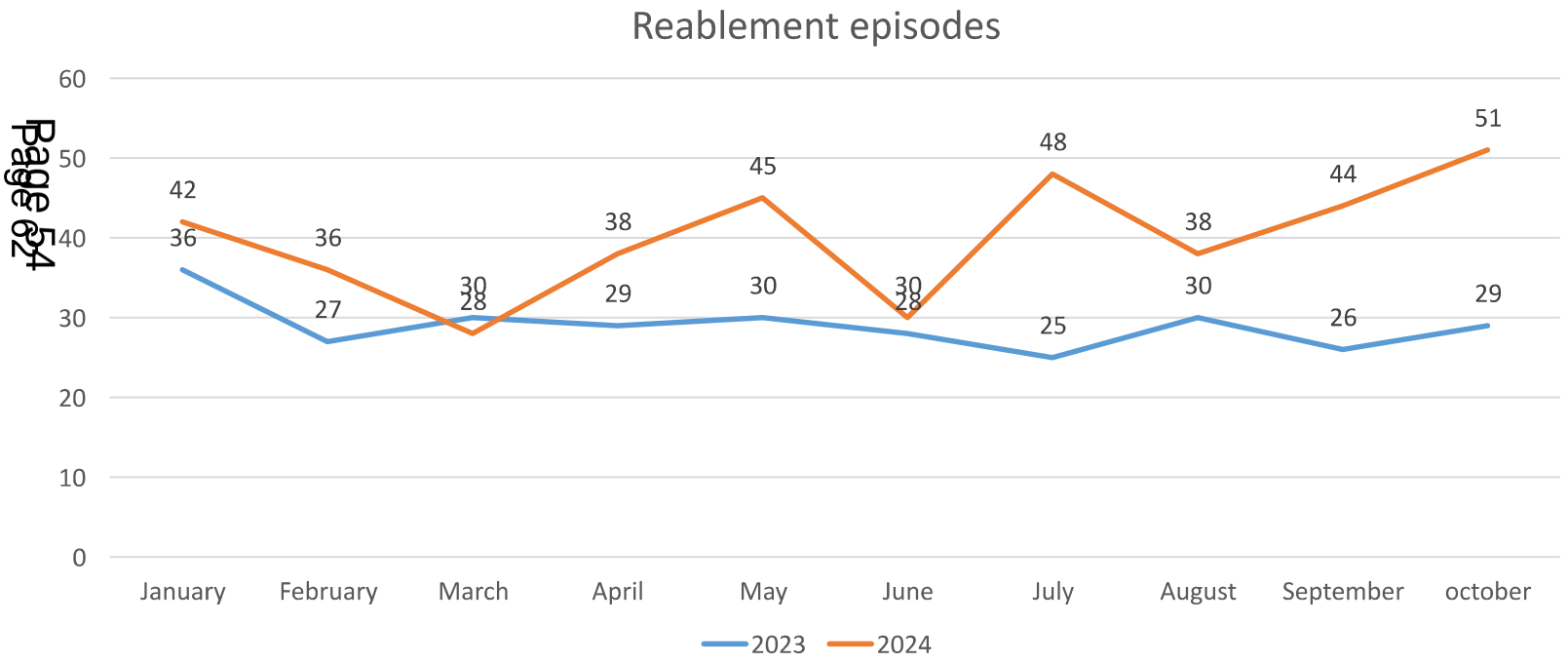


The profile of the impact of D2A in South Oxfordshire is consistent with the impact elsewhere in Oxfordshire

Data from Oxfordshire County Council Home First team

Reablement totals 2023 vs 2024

RG9 Henley, RG4 Sonning Common, RG 8 Goring Woodcote, OX9 Thame, OX49 Watlington, OX10 Wallingford, OX39 Chinnor.



Data from Oxfordshire County Council Home First team

The trend is broadly the same as for the rest of Oxfordshire and shows a significant year on year increase

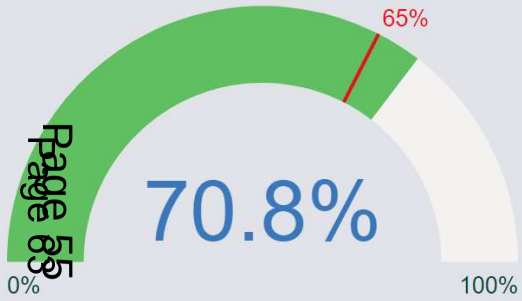
Reablement Performance (completed episodes)

OXFORDSHIRE COUNTY COUNCIL

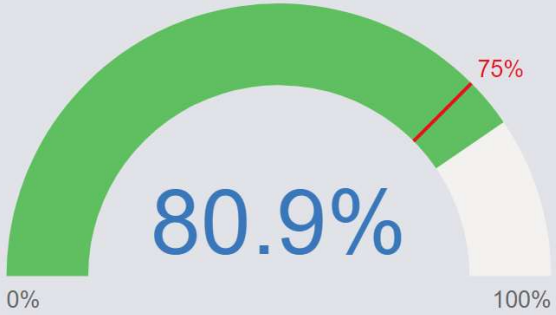
Provider	Team	Zone	Period	Location
All	All	3	Multiple selections	Multiple selections

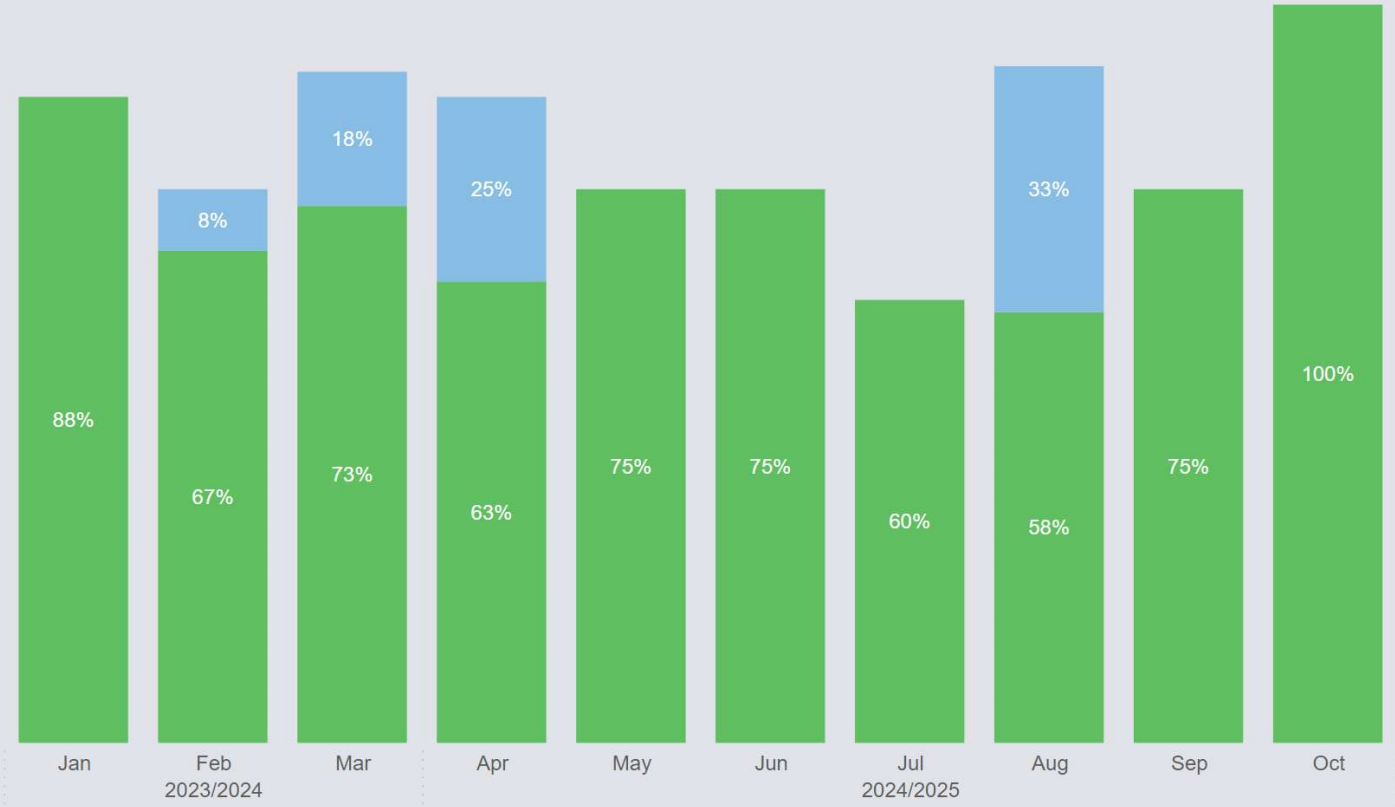
87	3	89	63	72
Episodes (LAS)	Active Episodes	Episode Completed	Independent	Independent/Reduced (ADSS)

Discharged Independent



Discharged Independent/Reduced





Data from Oxfordshire County Council Home First team

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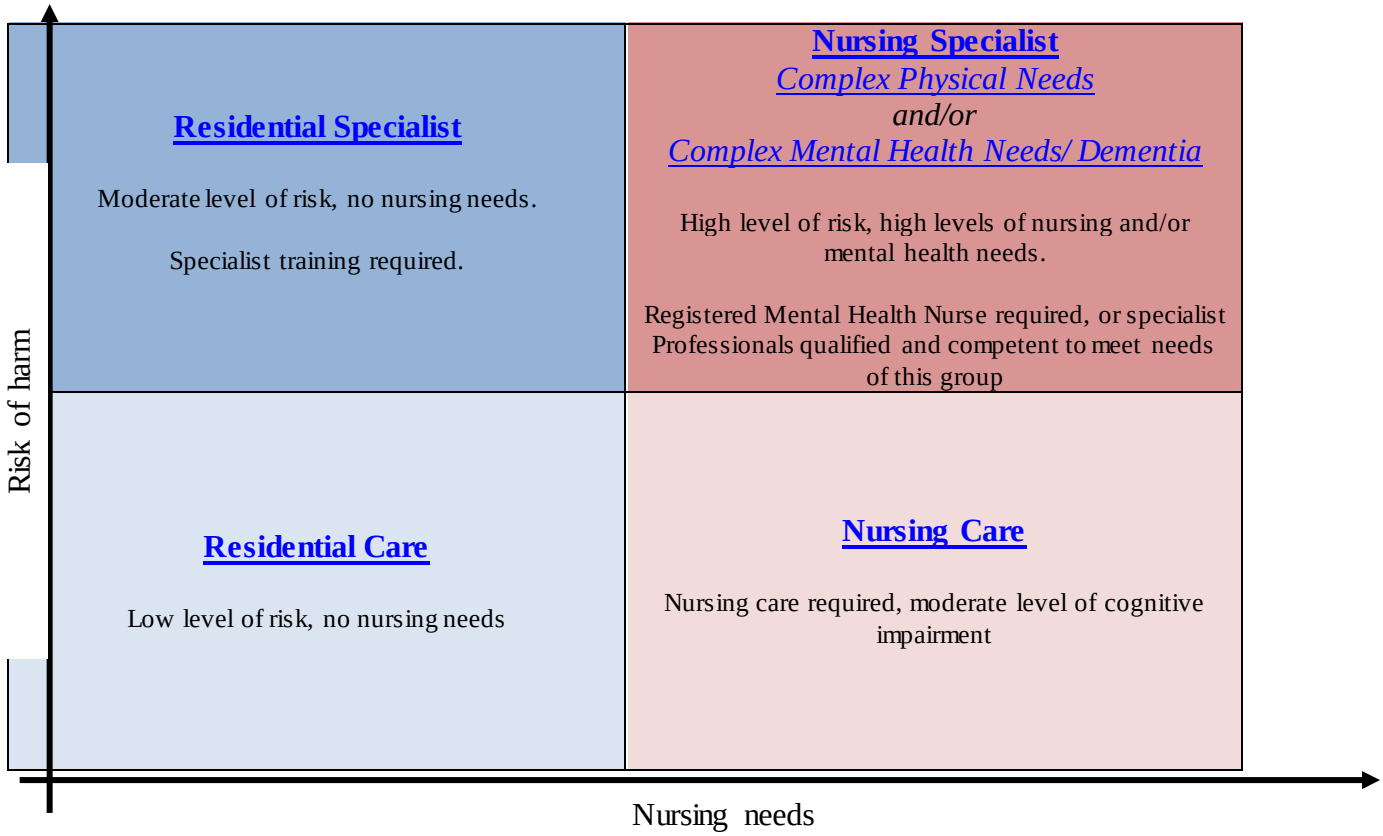
Care Bands-Care Homes

Introduction

This document sets out detail for the care bands 1-4. The care bands include:

- Residential Care
- Residential Specialist
- Nursing Care
- Nursing Specialist- *Complex Physical Needs*
- Nursing Specialist - *Complex Mental Health Needs/ Complex Dementia Needs*

All such settings will provide care in a person-centred, strength-based approach and will set goals that ensure we maximise independence where possible.



Residential Care

In most cases, those not requiring support at night will have their needs met in the community unless the care support during the day exceeds the level that can be met with homecare or other support. *e.g., Where a person is leaving their home and placing themselves at risk between visits.*

People in residential care will require a *substantial* to *extensive* level of assistance with activities of daily living over a 24-hour period.
They will have physical care needs **and/or** mental health needs, but they will not require a qualified nurse on duty. They may receive input from external services such as Community Mental Health Team or District Nurses.

Physical care needs

These include assistance with/ or prompting for:

- Washing and dressing
- Using the toilet
- Having meals
- Bathing
- Medication
- Manual handling for transfers/mobility. *This support may require equipment such as hoist and the support of 1 or 2 carers.*
- Specialist care plans for areas of significant frailty/risk. *e.g., diet, manual handling, skin care regimes, falls management.*
- In residential homes District Nurses can undertake the nursing needs. *e.g., catheterisation, bladder washouts, dressing leg ulcers, administering insulin, suppositories,* and other medications. Some health tasks may be considered appropriate to delegate to Care Home staff. Any such tasks will be discussed with the Care Home in advance.
- Compression stockings and other prescribed supports such as leg wraps, and splints.

This is not an exhaustive list.

Mental Health needs

These needs may include an extensive degree of cognitive impairment and disorientation and may be subject to Dols (Deprivation of Liberty Safeguards). Individuals may have reduced understanding of needs/risks which requires support to minimise risk and improve quality of life. These may present as one or more of the following in addition to some the physical needs described above:

- Evidence of low-level resistance to the delivery of care, challenging promotion of hygiene, safety and nutrition which requires a level of understanding and skilled intervention.
- Some self-neglect which are helped by staff intervention and promoting.
- Some risk requiring use of assistive technology for falls/disorientation *for example door/bed sensors*.
- May require pressure relieving equipment and low-level management of pressure areas.
- Episodes of restlessness *including the risk of non-purposeful leaving of their home when in the community and risk or being lost/not road safety aware etc.*

- Evidence of low-level agitation, irritability, or inappropriate behaviour that staff need anticipate and respond to.
- Low risk of self-neglect and non- compliance
- Low to Moderate risk of active attempts to leave the property.

This is not an exhaustive list.

Individuals in this care band should not require higher ratios of staffing i.e., are generally compliant with support and encouragement, and robust care planning to anticipate needs/triggers.

Residential Specialist

In addition to the residential care needs, people in Residential Specialist care will require a moderate level of support/monitoring and assistance with mental health needs which present with a moderate intensity. They may have high intensity and frequency of falls.

These residents **will not** have nursing care needs or will have nursing needs that could be met via an external service such as a District Nurse. This group will not need the constant supervision or intervention of a Registered Mental Health Nurse. They may be subject to Deprivation of Liberty Safeguarding (DoLS).

*Residential Specialist is needs specific**,** not diagnosis-led, and requires specialist interventions due to the intensity of care needs.* ***A diagnosis of dementia does not automatically mean the person needs this level of care.***

The person will require one or more of the following:

- A specialist staffing environment for people needing mental health support. *This may include a higher staffing ratio. The staff will need to have received enhanced training to meet the needs of the Individuals as described below. Some health tasks may be considered appropriate to delegate to Care Home staff. Any such tasks will be discussed with the Care Home in advance.*

- Assistance and risk planning for challenging behaviour which includes:
    - A moderate level of aggression or violence towards staff/residents,
    - Moderate disinhibition,
    - A moderate level of noisiness or restlessness,
    - A moderate level of resistance to necessary care and treatment (this may therefore include non-concordance moderate level of non-compliance with care delivery/medication),
    - Moderate fluctuations in mental state,
    - Moderate levels of frustration associated with communication difficulties.
    - A low level of inappropriate interference with other residents (low risk of retaliation),
    - identified historical risk of suicide,
    - A moderate risk to self and others,

- Active attempts to leave the property,
- Continued high risk of self-neglect and non- compliance.
-

This is not an exhaustive list.

Nursing Care

This group will require 24-hour access to a Registered Nurse on site in the Care Home and is likely to require daily interventions including care planning and supervision due to complexity of decision making and risk management.

NHS Funded Nursing Care (FNC) is provided by the NHS to Care Homes with nursing staff to support the provision of care by a registered nurse for those individuals assessed as having higher physical dependency with regular nursing needs. They may also have a low level of mental health and emotional needs.

It is important to note FNC is not related to diagnosis but relates to assessed health care needs. To receive FNC or 100% CHC, a referral will need to be made to the CHC (Continuing Health Care) team via a checklist. This will identify if the individual is eligible for FNC or a full assessment to determine eligibility for full CHC funding.

A person needing Nursing Care will require one or more of the following:

- Care planning and review of health-related care, as well as social care. *Including mental health and emotional needs*.
- Monitoring of fluctuating condition and / or administration of PRN medication *such as psychotropics e.g., Lorazepam*
- Complex pain management
- Administration of controlled drugs (opiates) and monitoring of effectiveness and side effects. This will include administration of medication via an injection. Medications may be scheduled or prn (none -scheduled).
- Routine Care of PEG and naso gastric feeding tube (NG Tube)
- Provision of appropriate pressure relieving equipment and frequent turning due to skin integrity,
- Aseptic dressings
- Complex manual handling *e.g., due to pressure damage or contractures*
- Risk management *e.g., for high levels of falls, nutrition, skin integrity, etc*
- Monitoring and management of diabetes
- Monitoring and management of significant weight loss/gain
- Specialist dressing regime in place for wounds, ulcers, and management of pressure damage.
- Low level oxygen therapy (24%).
- Room air ventilators via a facial or nasal mask.

- Continuous Positive Airways Pressure (CPAP) to manage obstructive apnoea during sleep.
- Seizure management
- Liaison with relevant MDT *(CMHT, Physio, OT, SALT)* as required.

This is not an exhaustive list. Individuals in this group may require Double Handed Care and may be weight bearing or none weight bearing.

Mental Health needs

These needs may include a low to moderate degree of cognitive impairment and disorientation that reduces their understanding of needs/risks, which require support to minimise risk and improve quality of life. These may present as one or more of the following of the following:

- Cognitive impairment, general confusion, or disorientation.
- Evidence of low to moderate levels of resistance to delivery of care, challenging promotion of hygiene, safety and nutrition which requires skilled intervention.
- Some self-neglect which is helped by staff intervention.
- Some risk requiring use of assistive technology for falls/disorientation *for example door/bed sensors*.
- Episodes of restlessness *including the risk of non-purposeful leaving of their home when in the community and risk or being lost/not road safety aware etc.*
- Evidence of low to moderate level agitation, irritability, or inappropriate behaviour that staff need anticipate and respond to.

This is not an exhaustive list. This group should not require higher ratios of staffing i.e., are generally compliant with support and encouragement, and robust care planning to anticipate needs/triggers.

Nursing Specialist

Nursing Specialist category is separated into Physical and Complex Mental Health/Dementia needs. An individual may have needs in one or both categories. The individuals primary need will be used to select the category they fall under. It is anticipated that Service Providers may have different units to accommodate these needs to manage the primary need.

It is important to note that individuals in this category will not automatically be eligible for CHC funding. Any individuals that are deemed suitable will need a referral to CHC as per CHC guidance. Once a checklist is received the CHC team will determine if the individual is eligible for FNC or a full assessment to determine eligibility for full CHC funding.

Complex Physical needs

A person with complex physical needs requiring Nursing Care Specialist care will require any of the interventions listed for 'Nursing Care' as well as one or more of the following management interventions including:

- Multiple wounds; *destruction and deep tissue wounds extending to underlying bone, tendon, or joint capsule,*
- Oral suction,
- Complex PEG,
- A non-invasive device that stimulates and maintains breathing (bipap or non-invasive ventilation,
- Complex bowel management; *including manual bowel evacuation,*
- A consistently high risk of frequent falls requiring ongoing risk assessment and management,
- Administering scheduled and prn (none scheduled) medication including injections.
- Tracheostomy (trachy) where the individual is dependent on staff to assist with trachy care which may include shallow suctioning and/ or tube changing/changing dressings. This relates to none ventilated tracheostomy,
- Administration of peritoneal dialysis.

This is not an exhaustive list. These people may also have Complex Mental Health/Dementia Needs.

Complex Mental Health/ Dementia Needs

A person with complex mental health/ dementia needs requiring Nursing Care Specialist care will require any of the interventions listed for 'Nursing Care' and high levels of cognitive impairment and associated behaviours that require different techniques and approaches. The person's primary need is dementia or mental health related.

The person will require one or more of the following management interventions including:

- A specialist staffing environment for people needing **mental health support**. This may include a higher staffing ratio. It is anticipated that a Registered Mental Health Nurse or other specialist professionals qualified to manage mental health for this group of people will be required. Staff will need to be trained in recognising deterioration, identifying triggers for certain behaviours, and can create care plans and risk assessments to manage and mitigate against this.
- Assistance and risk planning for challenging behaviour which include one or more of the following:
    - A high level of aggression or violence,
    - Severe disinhibition,

- Intractable noisiness or restlessness,
- Moderate to High levels of resistance to necessary care and treatment (this may therefore include non-concordance and non-compliance with care delivery/medication),
- Severe fluctuations in mental state; *may include hallucinations and/or mood disturbances that may require periods of intensive support,*
- Extreme frustration associated with communication difficulties,
- A high risk of inappropriate interference with other residents (risk of retaliation),
- An identified high risk of suicide,
- A high risk to self, others and property,
- Active attempts to leave the property,
- Likely to be mobile and disoriented.
-

This is not an exhaustive list.

100% CHC funding

If a person requires ANY of the above nursing care, they may be eligible for FNC or 100% CHC funding and the registered Care Home Nurse or other appropriately qualified professional (as mentioned in the CHC guidance) must complete a CHC checklist to determine eligibility.

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