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Notice of a Meeting

Performance Scrutiny Committee
Tuesday, 4 February 2020 at 1.00 pm
Rooms 1&2 - County Hall, New Road, Oxford OX1 1ND

Membership

Chairman Councillor Liz Brighouse OBE
Deputy Chairman - Councillor Jenny Hannaby

Councillors:	Nick Carter	Liz Leffman	Judy Roberts
	Mike Fox-Davies	Charles Mathew	Michael Waine
	Tony Ilott	Glynis Phillips	Liam Walker

Notes: ***Date of next meeting:*** *12 March 2020*

What does this Committee review or scrutinise?

- The performance of the Council and to provide a focused review of:
  - Corporate performance and directorate performance and financial reporting
  - Budget scrutiny
- the performance of the Council by means of effective key performance indicators, review of key action plans and obligations and through direct access to service managers, Cabinet Members and partners;
- through call-in, the reconsideration of decisions made but not yet implemented by or on behalf of the Cabinet;
- queries or issues of concern that may occur over decisions being taken in relation to adult social care;
- the Council's scrutiny responsibilities under the Crime and Justice Act 2006.

How can I have my say?

We welcome the views of the community on any issues in relation to the responsibilities of this Committee. Members of the public may ask to speak on any item on the agenda or may suggest matters which they would like the Committee to look at. **Requests to speak must be submitted to the Committee Officer below no later than 9 am on the working day before the date of the meeting.**

For more information about this Committee please contact:

Chairman	-	Councillor Liz Brighouse E.Mail: liz.brighouse@oxfordshire.gov.uk
Policy & Performance Officer	-	Lauren Rushen, Policy Officer, 07584 909530, lauren.rushen@oxfordshire.gov.uk
Committee Officer	-	*Colm Ó Caomhánaigh, Tel 07393 001096* *colm.ocaomhanaigh@oxfordshire.gov.uk*

Yvonne Rees
Chief Executive

January 2020

About the County Council

The Oxfordshire County Council is made up of 63 councillors who are democratically elected every four years. The Council provides a range of services to Oxfordshire's 678,000 residents. These include:

schools	social & health care	libraries and museums
the fire service	roads	trading standards
land use	transport planning	waste management

Each year the Council manages £0.9 billion of public money in providing these services. Most decisions are taken by a Cabinet of 9 Councillors, which makes decisions about service priorities and spending. Some decisions will now be delegated to individual members of the Cabinet.

About Scrutiny

Scrutiny is about:

- Providing a challenge to the Cabinet
- Examining how well the Cabinet and the Authority are performing
- Influencing the Cabinet on decisions that affect local people
- Helping the Cabinet to develop Council policies
- Representing the community in Council decision making
- Promoting joined up working across the authority's work and with partners

Scrutiny is NOT about:

- Making day to day service decisions
- Investigating individual complaints.

What does this Committee do?

The Committee meets up to 6 times a year or more. It develops a work programme, which lists the issues it plans to investigate. These investigations can include whole committee investigations undertaken during the meeting, or reviews by a panel of members doing research and talking to lots of people outside of the meeting. Once an investigation is completed the Committee provides its advice to the Cabinet, the full Council or other scrutiny committees. Meetings are open to the public and all reports are available to the public unless exempt or confidential, when the items would be considered in closed session.

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, giving as much notice as possible before the meeting

A hearing loop is available at County Hall.

AGENDA

1. Apologies for Absence and Temporary Appointments

2. Declarations of Interest - Guidance note on back page of the agenda

3. Minutes (Pages 1 - 8)

To approve the minutes of the meeting held on 9 January 2020 and to receive information arising from them.

4. Petitions and Public Address

5. Review of Mental Health Social Work services and contracts (Pages 9 - 32)

Oxfordshire's Health Overview Scrutiny Committee and Oxfordshire County Council Performance Scrutiny have asked that matters relating to the delivery of mental health support to people in Oxfordshire are brought before them for scrutiny. This item includes two reports.

S75 Adult Mental Health Social Work report
They have asked to be presented detail on the Section 75 Partnership agreement between OHFT and OCC covering the delivery of social work and the outcome of the transfer of the Older Adult Mental Health Team back into the council. It also includes team performance, the number of people supported and an overview of s. 117 funding.

The Committee is RECOMMENDED to note the report.

Mental Health Outcomes Based Contract
They have also asked to examine Mental Health Outcomes Based Contract between OHFT and OCCG (OCC contribute funding to this contract) covering the delivery of all mental health support to people with particular conditions, including inpatient care, community support, wellbeing and employment support, and housing.

This paper provides the Centre for Mental Health Review of Oxfordshire Mental Health Outcomes Based Commissioning Contract Summary Report and the next steps being taken by OCCG in relation to the contract.

The report recognises the way Oxfordshire commissioners and providers have pioneered the model of outcomes based commissioning, and whilst the system has ongoing challenges to address, the integrated way of working across the partners is positive and beneficial for service users and carers.

The Committee is RECOMMENDED to note the report.

6. Delayed Transfers of Care and Reablement (Pages 33 - 78)

This report provides an overview of Delayed Transfers of Care (DToC) in Oxfordshire. It includes recent performance compared nationally and locally as well as a summary of the challenges facing the Health & Social Care System that have on impact on DToC performance.

Oxfordshire is one of the worst performing systems in the country in terms of DToC consistently ranking in the bottom quartile nationally, and for the current financial year is ranked 147th out of 149 authorities . It is recognised that being delayed in hospital has a detrimental impact on a person's health and wellbeing. It is therefore critical that Oxfordshire's health & social care system partners work together to improve on recent poor performance in this area.

There are a number of challenges which impact on this performance, some of these challenges are being experienced by systems across the country, whilst others are specific to Oxfordshire. These are described in this paper as well as work that is underway to mitigate these challenges. As requested by the Performance Scrutiny Committee there is a specific focus on Reablement.

The Committee is RECOMMENDED to note the report.

7. Committee Programme (Pages 79 - 80)

To review the Committee's Work Programme.

Declarations of Interest

The duty to declare…..
Under the Localism Act 2011 it is a criminal offence to
(a) fail to register a disclosable pecuniary interest within 28 days of election or co-option (or re-election or re-appointment), or
(b) provide false or misleading information on registration, or
(c) participate in discussion or voting in a meeting on a matter in which the member or co-opted member has a disclosable pecuniary interest.

Whose Interests must be included?
The Act provides that the interests which must be notified are those of a member or co-opted member of the authority, **or**

- those of a spouse or civil partner of the member or co-opted member;
- those of a person with whom the member or co-opted member is living as husband/wife
- those of a person with whom the member or co-opted member is living as if they were civil partners.

(in each case where the member or co-opted member is aware that the other person has the interest).

What if I remember that I have a Disclosable Pecuniary Interest during the Meeting?.
The Code requires that, at a meeting, where a member or co-opted member has a disclosable interest (of which they are aware) in any matter being considered, they disclose that interest to the meeting. The Council will continue to include an appropriate item on agendas for all meetings, to facilitate this.

Although not explicitly required by the legislation or by the code, it is recommended that in the interests of transparency and for the benefit of all in attendance at the meeting (including members of the public) the nature as well as the existence of the interest is disclosed.

A member or co-opted member who has disclosed a pecuniary interest at a meeting must not participate (or participate further) in any discussion of the matter; and must not participate in any vote or further vote taken; and must withdraw from the room.

Members are asked to continue to pay regard to the following provisions in the code that *"You must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself"* or *"You must not place yourself in situations where your honesty and integrity may be questioned…..".*

Please seek advice from the Monitoring Officer prior to the meeting should you have any doubt about your approach.

List of Disclosable Pecuniary Interests:
Employment (includes"*any employment, office, trade, profession or vocation carried on for profit or gain*".), **Sponsorship, Contracts, Land, Licences, Corporate Tenancies, Securities.**

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Glenn Watson on **07776 997946** or glenn.watson@oxfordshire.gov.uk for a hard copy of the document.

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PERFORMANCE SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 9 January 2020 commencing at 10.00 am and finishing at 2.50 pm

Present:

Voting Members:	Councillor Liz Brighouse OBE – in the Chair
	Councillor Jenny Hannaby (Deputy Chairman) Councillor Nick Carter Councillor Tony Ilott Councillor Liz Leffman Councillor Charles Mathew Councillor Glynis Phillips Councillor Judy Roberts Councillor Michael Waine Councillor Liam Walker

Officers:

Whole of meeting	Lorna Baxter, Director for Finance; Lauren Rushen, Policy Officer; Colm Ó Caomhánaigh, Committee Officer

Part of meeting

Agenda Item	**Officer Attending**
5	Simon Furlong, Corporate Director Communities; Ansaf Azhar, Corporate Director of Public Health; Stephen Chandler, Corporate Director for Adult Services; Claire Taylor, Corporate Director Customers and Organisational Development; Ben Threadgold, Policy and Performance Service Manager.
5 and 6	Lucy Butler, Corporate Director for Children's Services
6	Jayne Howarth, Head of SEND

The Scrutiny Committee considered the matters, reports and recommendations contained or referred to in the agenda for the meeting, together with a schedule of addenda tabled at the meeting and agreed as set out below. Copies of the agenda, reports and additional documents are attached to the signed Minutes.

1/20 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Apologies were received from Councillor Mike Fox-Davies.

2/20 DECLARATIONS OF INTEREST - GUIDANCE NOTE ON BACK PAGE OF THE AGENDA

(Agenda No. 2)

There were no declarations of interest.

3/20 MINUTES

(Agenda No. 3)

The minutes of the meeting on 13 November 2019 were approved and signed.

Regarding 62/19, Councillor Glynis Phillips asked if the Council Leader has raised the issue of information sharing at the Health and Wellbeing Board and with the County Councils Network. The Council Leader confirmed that he had.

4/20 CORPORATE PLAN AND SERVICE AND RESOURCE PLANNING 2020/21 - 2023/24

(Agenda No. 5)

Lorna Baxter gave a presentation with a brief overview of Service and Resource Planning. Because the period for public consultation only closes after the Cabinet meeting and there is still information outstanding relating to the budget, the Council Leader and Director for Finance will need to be mandated to make any changes that emerge. The date for publication of amendments to the Cabinet's budget by opposition and other groups has been extended to Friday 7 February 2020.

Councillor Liz Leffman asked on behalf of Councillor Emily Smith if all motions passed by Council have been taken on board. Lorna Baxter responded that the Directors ensure that they are picked up.

Communities

Simon Furlong highlighted some of the proposals:

- Any changes to fees have been benchmarked against what other authorities charge.
- The increase in demand around planning applications needs to be met especially in relation to the natural environment aspects.
- A survey of our trees has identified that increased work will be needed over the next three years.
- S106 monies will be invested in a new software system to enable the Council to respond to planning consultations in a timely way.
- There is the potential to generate income from the Travel Planning Team's modelling for local planning and for developers on the travel impact of developments which is a chargeable service.
- LED replacement has not met the targets and so there will be a delay in the savings. A new procurement process is underway to minimise the impact.
- Increased charges at recycling centres apply only to non-residential waste.
- The costs of implementing the Permit Scheme for highways works are lower than predicted resulting in savings on previous estimated cost of the scheme.
- Two new vegetation clearing gangs will work on programmes developed with local member input.

- Four minor works gangs, currently revenue-funded will be reallocated to the Skanska contract and funded from the capital programme.
- The savings on SEN Transport come from a change in the operating model and will be delivered by the transport team.
- There has been a recalculation of the cost of firefighter pensions with an impact in Year 2.

Officers responded to issues raised by Members as follows:

- There is no specific budget for new trees, just for maintenance. The Council works with the District and City Councils as well as developers.
- The review of the system on planning consultations will include the provision of councillor information.
- The Strategic planning team is working with two bus companies on a bus strategy including connectivity.
- The Council is working towards having a cycle network across the county.
- Street lighting upgrading will ensure where appropriate it is coordinated with footpath renewal plans. The figures on LED installation can be circulated.
- Air quality is not specifically a climate action issue but is being dealt with by the same team.
- The administration costs of the Permit Scheme are significant but less than originally thought. It's not just about money though, the scheme gives the Council control over road works. There will be fines for works that do not comply with the Road Traffic management act through Fixed penalty notices.

Commercial Development, Assets and Investment

Simon Furlong summarised the proposals:

- Essential investment includes development of the facilities management (FM) team to provide coverage across the full property portfolio post-Carillion as well as improving the coverage of security services.
- The replacement of heating and other FM systems in OCC assets is profiled to be managed over the MTFP.
- The joint agreement on leisure centres for school use requires expenditure on a level of maintenance.

Councillor Judy Roberts asked about the savings on Joint Use Agreements in the following two years. Simon Furlong clarified that the budget pressure was a one-off pressure to complete the works in years 1 and 2 and it was then not required in future years and therefore shown as a minus figure in the budget line.

Public Health

Ansaf Azhar introduced this section noting that £30m from central government is ring-fenced for public health – about 80% of this is spent on commissioned services. Most of the commissioned services are delivered universally. However, health inequality is key issue. There are ten wards in Oxfordshire have areas that are in the 20% most deprived in the country. Therefore, there is a real need to deliver targeted services to these communities. Overall smoking prevalence has come down but in certain groups the prevalence is still stubbornly high. Therefore, the Smoking cessation services will move more towards a targeted provision to focus on the sectors that retain a high-level of smoking such as mental health patients, routine

manual workers and BAME communities. There will be more on upstream prevention; changing the environment to promote healthy behaviours through the healthy place shaping agenda.

Officers responded to Members' questions as follows:

- Smoking is still the biggest cause of ill health and a big driver of health inequality.
- Online testing in the sexual health area is more efficient and more popular with younger people who are the biggest users of the service. It involves receiving and returning self-testing packs. This will bring about a greater degree of impartiality and therefore improve access to sexual health services, especially in the rural communities.
- Weight management services are currently universal. The service is to double its capacity. Over 50% of Oxfordshire adults are overweight or obese. Other approaches are needed with this national problem.
- Public Health has chosen to take on the funding of School Vision Screening when OUH Trust funding ceases as it is an important preventative scheme.

Children's Services

Lucy Butler highlighted a number of items in this directorate. Early intervention on SEND is being introduced. Other increases are required to manage demand especially in High Needs SEND support. This includes additional and direct support to schools to enable children to remain in their current school.

Members raised a number of issues and officers responded as follows:

- The Council is not charging for the extra behavioural support to schools as this would be counterproductive. Spending on this is a good investment. Schools vary on how they handle these issues but the Council is sharing a model of good practice.
- The provision for early intervention on SEND is modest and more may be needed next year.
- The provision for care leavers up to the age of 25 includes a staff component – personal advisers provide help. The Council also works with district and city councils on housing.
- The Cabinet Advisory Group on post-16 school transport suggested some small savings but numbers are increasing. The lack of special schools in the county contributes to the problem as long distances can be involved.
- National policy is that the local authority takes responsibility for excluded students. The County Councils Network is lobbying on this. If children stayed on the school roll it would have high impact.
- Twenty new schools will be provided in the next six years – some will include SEND facilities. However, the Council does not control the location of all of these schools.
- Savings have not been made in the review of third party spend because there is an inadequate supply of services for children with complex needs driving the costs up.
- The increase in safeguarding support is related to the Council's statutory duties. However, recent Ofsted inspections have highlighted an increasing number of schools are not meeting their own safeguarding duties.
- Spending on the Family Safeguarding Model will lead to savings later.

The Chairman welcomed the additional investments proposed but expressed concern whether the Council had the capacity to deliver. Lucy Butler responded that staff retention had been a problem, but this will improve with the Family Safeguarding model because it involves more preventative work.

Adult Services
Stephen Chandler introduced this section. The goal is to help people to be as independent as possible and at home if possible. The Council does not do most of the work itself but works with providers and in some cases individuals. On average, home care costs £23 per hour but in places this can be £40 to £50.

Austerity resulted in a retraction of services to the Care Act duties only. High costs for many people could have been avoided with earlier intervention. The Council is trying to redress this including work with community groups.

Officers responded to Members' questions as follows:

- Assistive technology includes the use of smart phones. It is well tested. The spending on this is really a 'pump-primer'.
- Oxfordshire is paying the second highest for home care – £23 per hour while the recommended rate is £18.70. It should not be so different from neighbouring counties. The Council is establishing a new plan and intends to be more robust in its work with the market.
- The CQC report three years ago pointed to an over-reliance on beds. The Council will spend to strengthen community capacity. This has been successful elsewhere in reducing demand on beds.
- Demand with working age adults is increasing nationally. More are surviving for longer.
- Spending on home care is reduced because there is less home care available.
- The Council is working with self-funders to help them make good decisions.
- Government grants will be base-lined except for General Social Care of £12m which falls out.

The Chairman asked to see comparisons with other counties on home care costs when reporting on Delayed Transfers of Care at the February meeting of the Committee.

Customers and Organisational Development
Claire Taylor invited questions:

- There are no plans to change the procedures for the Priority Fund which is being continued.
- The IT strategy has now got a full technological roadmap. There is investment in video conferencing and agile working. The Council is ahead of the curve on this. The main challenge is ensuring health and safety when working from home.
- The Council does not need to pay to get out of the old data centre contracts.

Corporate Plan and Outcomes Framework
Claire Taylor gave a presentation. There is no change in the vision but this version of the plan is more accessible. The outcomes framework is still very much a draft for feedback. It is not expected that there will be much cost in printing. Only about 200

copies of the last plan were produced – mainly for libraries. This version is designed to be viewed online and is only half the length.

Members made the following comments:

- The inclusion of individual stories was welcomed.
- It should be made clear the areas in which the Council has direct responsibility and where it has not.
- There should be measures relating to quality of life.
- There is concern as to the value of data from "Fix My Street".
- There is not enough about income generation from commercial organisations.
- Enforcement – especially in minerals and waste – should be included.

The Chairman thanked the officers and reminded Members that the Corporate Plan should be used to scrutinize the Council's performance going forward.

Review of charges

Lorna Baxter summarised that a 2% increase applies generally except where the market allows or where the Council is not recovering costs.

Members raised a number of issues and officers responded as follows:

- It is policy to recover full costs and it has been flagged to managers that this should include overheads.
- The Government has signalled a review of business rates given increased competition from online businesses. It is unlikely that any review will affect funding of local authorities.
- New Homes Bonuses were paid for four years but those for 2020/21 will be for that year only. All payments will fall out by 2022/23 though a review is expected as the Government still wants some reward mechanism for house building growth.
- The level of reserves is believed to be appropriate over the medium term. These are earmarked for specific purposes.

There was a discussion regarding charges for advice on highways. Councillors Mathew and Carter suggested that charges could be doubled while the Chairman expressed concern that this might be a disincentive to developers at a time when houses are needed.

Capital Programme Strategy

Officers responded to Members' questions as follows:

- The key areas in the IT Strategy are identity and access, hardware, unified communications and data. The amounts are in addition to those already earmarked.
- Money is being put aside for climate action which could be renewing heating systems for example.
- Property, including how we work with schools, is one of the themes being examined by the Climate Action Cabinet Advisory Group. This will lead to the development of a business case.

- Funding for responding to the Carillion legacy is included in the Capital Programme. The actual work and costs are still being assessed but some costs are less than expected.
- Suggestions such as using the pension fund for housing on Council land would need a business case to be examined by the Pension Fund Committee then to follow the investment strategy procedure.

Treasury Management
Lorna Baxter highlighted the increase in the limit for longer term lending to £200m until 2023/24 given the higher than forecast cash balances. She believed that the amount of external investments was at the appropriate level.

5/20 SEND INSPECTION FINAL REPORT
(Agenda No. 6)

Lucy Butler introduced the SEND Final Local Area revisit report. Ofsted and the Care Quality Commission visited Oxfordshire in 2017 and issued a written statement of action against the Local Area (Oxfordshire County council and the Clinical Commissioning Group)

Ofsted revisited the Local Area in October 2019 to monitor progress against the 5 areas of significant weakness identified in the previous report. They found that sufficient progress had been made on three of the five areas identified. The two areas requiring further improvement were:

- The quality and rigour of self-evaluation and monitoring and the limited effect it has had on driving and securing improvement.
- The quality of EHC Plans.

Jayne Howarth added that the Council is committed to improving both areas but engaging more closely with young people and families was a high priority.

Officers responded to Members questions as follows:
- Staff are encouraged to use more accessible language in communicating with parents but the issues are often very complex.
- No formal further visit by Ofsted/CQC will be undertaken as DfE have only commissioned one revisit for each Local Authority when given a Written Statement of Action. A new round of inspections is being considered by Ofsted, starting in 2021, however due to the number of authorities who have been given a statement of action, this might be delayed.
- Headteachers were very involved and advised inspectors that they were now really being challenged on exclusions. The Council is held accountable for exclusions across the county but does not control most of the schools involved, as they are now Academies.
- Inspectors also met with parents. Parents expressed concerns over the lack of involvement in strategic decisions and this is being addressed with a number of focus group sessions being arranged.
- It is expected that the new Family Safeguarding model will address some of the problems faced by parents.

- HOSC looked at CAMHS at its November meeting and asked for a further report for its February meeting.

The Chairman thanked officers for the report and for the progress made. She agreed with the report's finding that many parents remain unclear about who is accountable for different aspects of SEND provision. She also said that early psychological intervention was needed.

RESOLVED: to note the outcome of the SEND Local Area Re-Visit report, published on 23 December 2019.

6/20 WORK PROGRAMME

(Agenda No. 7)

The Chairman invited Members to email her with any suggestions for the work programme.

..... in the Chair

Date of signing 2020

Division(s): N/A

Performance Scrutiny Committee – 4 February 2020

Reviews of the Mental Health Outcomes Based Contract and the Section 75 Mental Health Social Work

Report by the Corporate Director of Adult Services

RECOMMENDATION

1. The Committee is RECOMMENDED to note the report.

Introduction

2. Performance Scrutiny have asked for a report regarding the Section 75 Partnership agreement between OHFT and OCC. The report is expected to cover the delivery of social work and the outcome of the transfer of the Older Adult Mental Health Team back into the council. It also includes team activity, the number of people supported and an overview of s. 117 funding.

3. Oxfordshire County Council's (OCC) contribution to the Mental Health section 75 Partnership Agreement pays for social work staff to deliver care act compliant functions of assessment, care planning and review and other mental health social work activities, on behalf of Oxfordshire County Council through Oxford Health Foundation Trust (OHFT) Adult Mental Health Community Teams (AMHTs), Early Intervention Service (EIS) and Forensic Service (FS).

Background

4. Along with the delivery of care act compliant functions the purpose of the s75 agreement is to facilitate the provision of integrated services by the Partners (OCC and OHFT) in the manner and locations specified in the agreement and to be limited to eligible people within the Council's borders.

5. The s75 agreement covers the staff in community teams. The community teams consist of three locality-based Adult/Integrated Mental Health Teams (AMHT/IMHT), an Early Intervention Service (EIS), and a Forensic Service (FS).

6. The governance and management oversight of the s75 partnership agreement is the role of the Mental Health Provider Joint Management Group (JMG); the terms of reference form part of the s75 Partnership agreement. This role includes monitoring of the budget, activity, staffing and service improvements.

The Pooled Budget

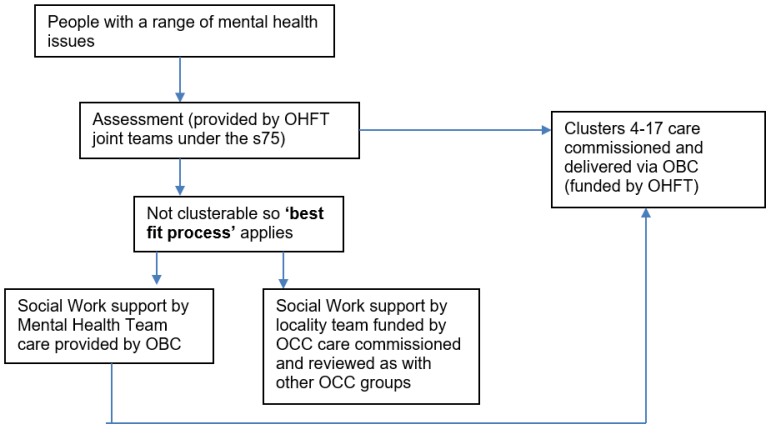
7. In 2018/19 the planned contributions to the s75 agreement by OCC were £1.8m and by OHFT was £5.8m for adults of working age.

8. The OHFT contribution to the s75 pooled budget comes from their funding from the Mental Health Outcomes Based Contract (OBC). The OBC is reviewed in detail in the associated paper; 'The Centre for Mental Health Review of Oxfordshire Mental Health Outcomes Based Commissioning Contract Summary Report'.

Eligibility

9. Eligibility for care under the 2014 Care Act is based on an assessment identifying how an individual's needs affect their ability to achieve relevant desired outcomes, and whether as a consequence this has a significant impact on their wellbeing. Eligibility is primarily determined through a Care Act Assessment. S75 social work is for any person for whom the Care Act indicates the need following, assessment for appropriate social care services and those needs are as a result of a mental health condition and/ or eligible for Aftercare under S117 Mental Health Act.

10. The s75 covers the statutory provision of assessment, care planning and review. People who meet the eligibility criteria for the Outcomes Based Contract have their support needs met from within this contract. This includes services sub contracted by OHFT from voluntary sector and independent sector providers. Social care support for people who do not meet the criteria for the OBC is funded via the OCC and OCCG Adults with Care and Support Needs Pooled budget.



11. The s75 partnership agreement also enables social work staff to facilitate the provision of a social care package for people meeting Care Act criteria in line with Oxfordshire County Councils "best fit" practice (as set out below). Where someone is eligible for assistance under Care Act criteria the care and recovery plan will be delivered through a personal budget. This care package is provided, as appropriate, either as a direct payment and/or via a sub-contracted service within the OBC (if eligible for an OBC service).

12. The s75 is defined as covering 'integrated mental health and social care services for adults of working age and mental health and social exclusion (vulnerable adults)'. The population covered by the s75 agreement is broader, and more focused on social need within mental health, than the population covered by the OBC.

Mental Health Social work staff

13. The total staffing numbers for the AMHT's is 168 WTE. This number does not include the staffing for the Forensic Service or the Early Intervention Service.

14. There are currently 41.5 whole time equivalent (WTE) posts funded by OCC's contribution to the s75 partnership agreement spread across the AMHT, Forensic Service, EIS and management (these consist of senior practitioner social workers, social worker and support worker roles). Of these, 4.7 WTE remain as OCC employees seconded to the NHS organisation (OHFT).

S75 Mental Health Social Work Team Activity

15. OHFT record social work activity on the OCC Social Work case management system (LAS) and on the OHFT case management system (Carenotes). At the end of August 2019, the OHFT S75 social work case load was 580.

16. The current average Mental Health Social Worker's case load is 24 cases (this considers wte and skill mix). These caseload figures are similar to what would be expected in other social work teams in the Council.

17. The figures from LAS and Care Notes combined are an accurate position of the case work being undertaken by s75 Social Work staff. Social Workers record cases in the relevant place which is either Care Notes, LAS or both depending on the nature of the work. There is a requirement for all statutory social work to be recorded on LAS.

Outcome of the transfer of Older Adults Mental Health Social Work

18. The OCC 6-month review on the outcome of the transfer reports that some of the prior concerns regarding staffing, processes and outcomes for people receiving services did not have the anticipated level of impact after transition.

19. All staff successfully TUPE'd to OCC, social workers are now embedded in the Council system and report to have greater clarity about their roles and expectations in relation to the Care Act.

20. Overall Older Adults Mental Health team activity, as recorded on LAS is at a higher level when comparing Older Adult Community Mental Health Team data (before the transfer). This was to be expected given that pre-transfer Older Adult Mental Health social workers were not using LAS fully.

Section 117 of the Mental Health Act

21. Section 117 of the Mental Health Act covers the provision of Aftercare after a person has been detained in hospital under an eligible section of the MHA. There is no power to charge for Aftercare services. The MHA Code of practice states that Aftercare should be interpreted broadly, and it can include things such as; medication, social care and supported accommodation and social activities. These Aftercare services are services which are intended to meet a need that

arises from or relates to a mental disorder and will reduce the risk of a person's mental health condition getting worse, and them having to go back to hospital. Aftercare is a joint duty of the Local Authority and the CCG.

22. 302 people are subject to s117 Aftercare in the Older Adults Mental Health Social Work team within OCC. These are now being jointly reviewed with OHFT to establish whether people still meet the s117 criteria.

23. OHFT are responsible for the care and management of s117's for adults. There are 1664 (data from January 2019) adults of working age subject to s117 aftercare in the Adult Mental Health Teams within OHFT. OHFT are in the process of implementing the jointly developed s117 protocol. Cases are reviewed at the regular review times and work is underway to ensure that LAS is fully update with s117 information.

Conclusions

24. Data available from OHFT's case management system and the OCC case management system does provide the Council with a complete picture of activity relating to social care, care act compliant assessment and reviews. Some social care need is being met through the OBC sub contract services. These services are commissioned, and contract managed by OHFT.

25. OHFT are committed to improving the s75 social work data recording on the OCC case management system, LAS. Improvements can still be made particularly on evidencing the extent of care act eligibility within the service and ensuring social workers have enough time to undertake their statutory duties.

26. The Mental Health Provider JMG (OCC and OHFT) will continue to retain the responsibility for overseeing the s75 partnership arrangements including monitoring of budget, performance, staffing and service development.

27. The continued collaboration between system partners will ensure ongoing delivery of quality care for people requiring support with their mental health and social care needs.

Stephen Chandler
Corporate Director of Adult Services

Background papers: None

Contact Officer: Eleanor Crichton Oxfordshire County Council
(Section 75 Mental Health Social Work)

February 2020

Division(s): N/A

Performance Scrutiny Committee – 4 February 2020

Mental Health Outcomes Based Contract

Report by the Corporate Director of Adult Services

RECOMMENDATION

1. The Committee is RECOMMENDED to note the report.

Executive Summary

2. Oxfordshire's Health Overview Scrutiny Committee and Oxfordshire County Council have asked that matters relating to the delivery of mental health support to people in Oxfordshire are brought before them for scrutiny.

3. They have asked to examine ***Mental Health Outcomes Based Contract*** *between OHFT and OCCG (OCC contribute funding to this contract) covering the delivery of all mental health support to people with particular conditions, including inpatient care, community support, wellbeing and employment support, and housing.*

4. This paper details the ***Centre for Mental Health Review of Oxfordshire Mental Health Outcomes Based Commissioning Contract Summary Report***

Summary

5. The outcomes-based contract (OBC) for mental health services runs from 1 October 2015 until 30 September 2020. The annual core value for 2019-20 is approximately £43.1m, which includes the Council's contribution of £6.2m. The contract covers support for just under 4,000 people with mental illness at any one time.

6. There is an option to extend the contract for a further 2 years after September 2020, and a review was undertaken to inform commissioners whether it is still meeting the needs of the population and so whether to take up that extension, as well as informing future mental health commissioning.

7. In October 2109, the OCCG Executive (as lead commissioner) received the Centre for Mental health report and agreed the proposed recommendations and to extend the contract for a further two years from September 2020; with:

    a. the intention to continue with OHFT as Lead Provider
    b. the intention to retain the current outcomes originally agreed and seek to ensure these are driving the service delivery
    c. recognition that benchmarking of investment shows per head of population Oxfordshire CCG invest less than peers and less than

national average on mental health services. Significant cost and activity pressures are being experienced in the adult mental health service and the related social care and OBC partner organisations. A phased proposal to begin to close the gap is under development.

d. recognition that the transformational change needs to be accelerated within the partnership and has not fully taken place as expected and current work between commissioners and OMHP will support taking this further forward over the coming years through a clear programme of work
e. More visibility of the funding flows to the third sector partners

Key Findings

Mental Health Outcomes Based Contract

8. The review of the Mental Health Outcomes Based Contract was commissioned by the Oxfordshire Mental Health Partnership (comprising OHFT, and the five voluntary sector partners), by OCCG, and by OCC.

In summary it states

> *The review concludes that Oxfordshire has pioneered the model of outcomes based commissioning in mental health and commissioners and providers should be congratulated for stepping out on an unknown and long road, for which no one had a map. There is a strong consensus among all stakeholders that the Partnership should continue. In doing so, it has the opportunity to learn and adapt: for example to develop more focused outcome measures, to address out of area or residential care placements and to continuously find ways of getting better value for money.*

9. The Centre for Mental Health produced this summary report which brings together the findings from all four workstreams; there are detailed reports available of each workstream if required. The majority of the findings were positive, and a high level summary of some of these is listed below:
    a. There has been improved communication and joint working between organisations, resulting in more holistic care
    b. Service users consistently fed back that staff were understanding, non-judgemental and compassionate, and helping them move forward in their recovery
    c. The OMHP has improved parity through better provision of physical health monitoring for people using mental health services, as a result, for example, there has been a reduction in the number of people on the caseload who smoke
    d. The OMHP has successfully increased the percentage of people on their caseload who are in work, meaningful activity and stable accommodation
    e. Being in the OMHP has provided greater financial security for third sector partners

f. OMHP can evidence integrated ways of working through joint initiatives such as, paid peer support workers on wards and in community teams, embedded third sector workers in community teams, embedded clinical support within intensive housing support provision, and all relevant OMHP partners are involved in routine system working e.g. case conferences, discharge planning.

10. The Partnership has faced some challenges:
    a. As a result of external pressures, including financial constraints in the local health economy
    b. Difficulties in being able to bring about large-scale change in service provision
    c. An increase in demand and complexity for services
    d. recognition that benchmarking of investment shows that per head of population Oxfordshire CCG invest less than peers and less than national average on mental health services

11. High level recommendations from the review include:
    a. The continuation of the OBC contract
    b. A review of outcomes, monitoring and responsibility for achievement
    c. Provision of commissioning support to implement change.

12. CQC
    In addition since the Centre for Mental Health report was published OHFT were inspected by the CQC in December 2019 and maintained their 'good' rating.

13. The report is in Annex 1

Stephen Chandler Corporate Director of Adult Services

Background papers: None

Contact Officer: Eleanor Crichton Oxfordshire County Council
(Section 75 Mental Health Social Work)

February 2020

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Centre for Mental Health

Review of Oxfordshire Mental Health Outcomes Based Commissioning Contract

Summary report

Version 5. final

Centre for Mental Health
London

Contents

Executive summary

Centre for Mental Health is an independent charity. Our aim is to identify effective mental health support through research and make known the evidence for best practice through influencing national mental health policy.

The Centre was commissioned by the Oxfordshire Mental Health Partnership to report on the achievements of the first 4 years of the Outcomes Based Commissioning Contract (OBC).

The Oxfordshire Outcomes Based Commissioning contract started on 1 October 2015 and is due to end on 31 September 2020. There is an option to extend it for a further two years. The six provider organisations within the Partnership are Oxford Health NHS Foundation Trust (the lead provider) and Restore, Response, Oxfordshire Mind, Elmore and Connection Support.

The Partnership's aims were to bring about seven outcomes for people of working age using mental health services in the county:

- People with mental illness will live longer
- Improved level of wellbeing and recovery
- Timely access to assessment and support
- People will maintain a role that is meaningful to them
- Continue to live in stable and suitable accommodation
- Better physical health
- Carers will feel supported

Most of these outcomes are currently being achieved by the measures agreed with the Partnership and its commissioners. The Partnership has also seen the creation of a number of new services, including a crisis café and a recovery college.

Among the benefits of the Partnership were improved joint working between organisations, greater financial security for third sector partners, and improved physical health monitoring for people using mental health services. The Partnership has also faced significant challenges, including overall financial constraints in the local health economy, difficulties in being able to bring about large-scale change in service provision and a recent rise in out of area hospital admissions.

The review concludes that Oxfordshire has pioneered the model of outcomes based commissioning in mental health and commissioners and providers should be congratulated for stepping out on an unknown and long road, for which no one had a map. There is a strong consensus among all stakeholders that the Partnership should continue. In doing so, it has the opportunity to learn and adapt: for example to develop more focused outcome measures, to address out of area or residential care placements and to continuously find ways of getting better value for money.

1. Introduction

Centre for Mental Health is an independent charity. Our aim is to identify effective mental health support through research and make known the evidence for best practice through influencing national mental health policy.

The Centre was commissioned by the Oxfordshire Mental Health Partnership to report on the achievements of the first 4 years of the Outcomes Based Commissioning Contract (OBC). The overall review of the OBC was undertaken in 4 streams, led by different organisations:

1. Experience of the services – led by Oxfordshire County Council and supported by OCCG and the OMHP
2. Practice review and reflections on partnership working – led by Centre for Mental Health
3. Desktop performance review – led by Oxfordshire Clinical Commissioning Group and SCW CSU
4. Financial review – led by Oxfordshire County Council

Centre for Mental Health has produced this short summary report which brings together the findings from all four workstreams.

2. Methodologies

Experiences of the services

The surveys were developed in partnership with the members of the OMHP. The first survey was developed for individuals who have used or are using the service to gain feedback relating to:

- The impact of the service
- How important and relevant the current outcomes are for individuals and what other outcomes are important for individuals
- What works about the current range of services provided under this contract and how they work together? What could be improved?

The second survey was for stakeholders, including GPs and referring agencies to provide an opportunity for feedback relating to:

- The impact of the OMHP
- The key issues for them
- Referral pathways
- Relationships with the services within the contract
- What works with the current service provision and what could be improved?

Every effort was made to ensure that the user survey was accessible to all individuals, to ensure fair representation of service user groups. The survey was available in both easy read and standard format. There was a combination of qualitative and quantitative data collected. The qualitative answers provided participants with the opportunity to raise a wide range of issues, resulting in a large amount of free text for analysis.

Practice review and reflections on partnership working

We undertook 15 individual or small group interviews, using a semi-structured interview question schedule, with Partner CEOs and Senior Managers, and a focus group with the OBC Partnership Senior Management Team (SMT), i.e. the Heads of Service across the six partner organisations.

Interviews were recorded and reviewed to identify common themes.

Desktop performance review

Oxfordshire Clinical Commissioning Group and SCW CSU provided a performance report.

Financial review

Each provider in the Oxfordshire Mental Health Partnership, including Oxford Health, completed a finance return providing a breakdown of the following information for financial years since the start of the contract in October 2015:

- Income and expenditure relevant to the contract
- Breakdown of direct service costs
- Breakdown of staffing costs and FTE's for 2018-19
- Sub-contracted costs
- High level activity

In addition, a desk top review of published accounts was undertaken of each of the third sector providers within the OMHP in order to understand the financial status of each organisation and assess their financial stability.

3. Background

The Oxfordshire Outcomes Based Commissioning contract started on 1 October 2015 and is due to end on 31 September 2020. There is an option to extend it for a further two years.

Services provided within this contract are for people aged 18-65 who have been assessed using HONOS cluster tool and meet the threshold of clusters 4-17. It is not clear how the partnership ensures provision for people who have the right to a social care mental health service under the Care Act. The funding provided to the partnership from Oxfordshire County Council for people with higher social care needs becomes largely invisible within the larger amount of health funding put into the contract.

The contract was let on a 'capable provider' basis, i.e. not openly tendered. Oxford Health was invited by the CCG to convene a group of capable providers and to put together a bid for the contract. This group became the partnership when the bid was subsequently accepted.

The six provider organisations are Oxford Health NHS Foundation Trust (the lead provider, i.e. the contract holder) and Restore, Response, Oxfordshire Mind, Elmore and Connection Support.

At the creation of the OBC it was proposed that money would flow from Oxford Health NHS Foundation Trust to the third sector to achieve the contract aims, this was envisaged to be a substantial transfer of financial resource achieved through the closure of a ward, enabling the third sector to provide more community housing, a crisis house and enhanced community support.

4. The outcomes

Oxfordshire mental health organisations, having appreciated the benefit of commissioning for outcomes, rather than prescribing individual services, held workshops with patients and carers to identify outcomes which were important to them. The outcomes chosen are:

- People with mental illness will live longer
- Improved level of wellbeing and recovery
- Timely access to assessment and support
- People will maintain a role that is meaningful to them
- Continue to live in stable and suitable accommodation
- Better physical health
- Carers will feel supported

5. Experience of the services

The summary of the experience workstream shows that people value the services they use. In terms of ease of access respondents reported finding it most easy to access Oxfordshire Mind, Restore and Response. The least easy were Elmore Community Services and Oxford Health.

Access to services was also raised as a key issue for focus group attendees, particularly in relation to accessing services when needed and the role of access in prevention of escalation of problems.

Where people did not find access easy the most common issues were:

- Waiting times, which often felt too long, were frustrating and hard to manage while dealing with a mental health condition, often without support.

- Inadequate referrals, such as the length of time to get a referral or not being referred for treatment when it was felt it was needed.
- A lack of information.

Several questions explored the quality of care and support, such as "What is good about the service?", "What could be better about the service you receive?", "Which part of the health and social care support you receive is most important to you?". The strongest positive related to the quality of staff. High quality, supportive staff was the most mentioned in response to the question "which part of the health and social care you receive is most important to you". Respondents talked about staff being "understanding" "non-judgemental" with words such as caring, kind, helpful, supportive, compassionate appearing repeatedly. In addition, staff help people to keep doing the things they want to do and support them to move forward in their recovery.

In response to the question "What could be better about the service you receive?", respondents identified the need for increased funding to provide more staff to deliver increased level of care and support of all types including group and one-to-one treatment sessions as well as learning or therapeutic activities. Also highlighted was the need for increased opening hours, including out of hours. Other areas for improvement related to waiting times, access and general organisation.

People were asked what things they needed support with in order to feel good, healthy and safe. This question was based around the outcomes agreed in the OBC. Whilst they were all relevant the most important area was an "improvement or stability in mental health" followed by "timely access to services".

The survey responses continually highlighted the value of holistic services to support recovery, particularly in terms of the type of support e.g. groups, one to ones, outdoor activities or having a safe place to be. Alongside this was the importance of a comfortable and non-judgemental environment to talk about issues as they arise and look at them in a different way. For example, environments such as those provided at Mind and Restore.

78% of people responding to the survey knew what to do if they found themselves in crisis. Although most of the respondents found the support they received helpful, some did not, stating that they had to rely on themselves or the support was not adequate and 27% advised that support was not there when they needed it. We note that these are considerably better %s than observed in national reports on experiences of crisis care?

Stakeholders, meanwhile, reported improved communication and joined-up working as a key positive for the OMHP as this has helped with the patient flow through the system. The strength of working as a group of providers came through strongly and the added value this can bring in terms of supporting people more effectively and also in attracting other funding opportunities. The improved communication has meant that organisations have worked better together and more effectively. Similarly, joint training has enhanced the knowledge of other organisations and opportunities have increased since the partnership began. The joint

referral system was seen as valuable. The partnership was seen as offering better services for patients providing the opportunity for "meaningful conversations about clients".

The following key points highlight the combined findings from both service user and stakeholder engagement exercises.

- The original intentions of the contract, in terms of outcomes are still relevant
- The value of holistic services to support recovery is significant
- Staff are consistently reported as being very supportive and are highly praised
- The provision of a comfortable non-judgemental environment is important
- A mixture of provision e.g. one to ones, groups, outdoor activities is valued
- There is a challenge in having access to services at the right time
- Partners are working together well but this could improve
- There is awareness amongst people who use services and stakeholders of the pressure on the system in terms of demand and funding

6. Practice Review and Reflections on the Partnership

The Partnership's aims were to bring about seven outcomes for people of working age using mental health services in the county:

- People with mental illness will live longer
- Improved level of wellbeing and recovery
- Timely access to assessment and support
- People will maintain a role that is meaningful to them
- Continue to live in stable and suitable accommodation
- Better physical health
- Carers will feel supported

Most of these outcomes are currently being achieved by the measures agreed with the Partnership and its commissioners. The Partnership has also seen the creation of a number of new services, including a crisis café and a recovery college.

Among the benefits of the Partnership were improved joint working between organisations, greater financial security for third sector partners, and improved physical health monitoring for people using mental health services. The Partnership has also faced significant challenges, predominantly as a result of external pressures, including overall financial constraints in the local health economy, difficulties in being able to bring about large-scale change in service provision and a recent rise in out of area hospital admissions.

The review concludes that Oxfordshire has pioneered the model of outcomes based commissioning in mental health and commissioners and providers should be congratulated for stepping out on an unknown and long road, for which no one had a map. There is a strong consensus among all stakeholders that the Partnership should continue. In doing so,

it has the opportunity to learn and adapt: for example to develop more focused outcome measures, to address out of area placements and to find ways of getting better value for money.

The reflections on the partnership report (Workstream 2) are:

- The OBC partnership as currently constituted should continue.
- The partnership should develop and action plan to achieve all the contract targets.
- The OBC partnership and the commissioners should identify resource for commissioning support.

7. Desktop performance review

Fig. 1 Years 1-3 Performance against outcome targets

Outcome Description	Contract Outcomes	Target	Y1 baseline setting	Y2	Y3	
People will live longer	1. Mortality age of the MH adult population (reduction in excess of under 75 age mortality rate)*	Achievement based on Public Health reporting	achieved	achieved	achieved	
People will improve their level of functioning	2a i: % aggregated improvement in score on validated recovery evaluation tool amongst service users in clusters 4-17 at most recent cluster review - **RECOVERY STAR**	55%	not achieved	achieved	achieved	
	2a.ii: % aggregated improvement in score on validated recovery evaluation tool amongst service users in clusters 4-17 at most recent cluster review - **QPR**	55%	KPI introduced in Y3		not achieved	
	2a. iii: % aggregated improvement in score on validated recovery evaluation tool amongst service users in clusters 4-17 at most recent cluster review - **SFQ**	50%	KPI introduced in Y3		not achieved	
	2a iv: % aggregated improvement in score on validated recovery evaluation tool amongst service users in clusters 4-17 at most recent cluster review - **CORE34** - Percentage of patients showing Clinical Change CORE -OM	33%	KPI introduced in Y3		achieved	
	2a v: % aggregated improvement in score on validated recovery evaluation tool amongst service users in clusters 4-17 at most recent cluster review - **CORE34** - Percentage of patients showing Reliable Improvement CORE- OM	33%	KPI introduced in Y3		achieved	
	2b: % of service users in clusters 4-17 under the care of OHFT with a reduction in intensity in HoNOS rating score at their most recent cluster review*	33%	partial achievement	achieved	achieved	target was increased in Oct 2018 from 30% to 33%
	2c i: % of service users who have been discharged from OHFT and are not readmitted to hospital at 28 days after discharge	93%	partial achievement	achieved	achieved	
	2c ii: % of service users who have been discharged from OHFT and are not readmitted to hospital at 90 days after discharge	88%	partial achievement	not achieved	achieved	
People will receive timely access to assessment and support	3: Percentage of all referrals to adult mental health teams that are categorised as crisis/emergency where the patient (and carer where applicable) and the referring GP are contacted within 2 hours.	90%	partial achievement	achieved	achieved	

People will maintain a role that is meaningful to them	5a: x% of service users in paid employment, undertaking a structured education or training programme or undertaking structured voluntary activity	60%	not achieved	achieved	achieved	target increased from 50 to 60% in Oct 2017
	5b: with at least x% of those, in paid employment	18%	not achieved	achieved	achieved	target increased form 16.75 to 18% in Oct 2017
People continue to live in stable accommodation	6: x% of service users living in stable accommodation		partial achievement	achieved	achieved	target increased from 70% to 72% in April 2017 and to 80% in Oct 2017
People will have fewer physical health problems related to their mental health	7a: % of current service users in clusters 4-8 whose impact on the urgent care system will reduce	80%	achieved	achieved	achieved	
	7b: reduction in % of people with BMI over 30	no target	not achieved	partial achievement	achieved	
	7c: % reduction in the prevalence of smoking amongst the service user population under the care of the contract	42.50%	partial achievement	achieved	achieved	

Local Quality Standards

Throughout the contract length some of the Local Quality Standards have been revised to report more meaningful measures.

Performance for the following KPIs should be noted:

- **Percentage of outpatient letters that are sent back to GPs (uploaded to CareNotes) within 10 calendar days (from April 2018 this was changed to 7 Calendar days**) – performance deteriorated from Sep 2017. Despite target changing from 10 to 7 on April working days in April 2018 OHFT took a considerable amount of time to adjust their reporting processes and started to report against the revised target from March 2019

- **Percentage of typed discharge letters that are sent back to GPs within 24 hours of discharge** – performance deteriorated since May 2018 and based on the feedback from the Trust, breaches occur mostly within the City Team due to admin staff issues (vacancies).

- **Adult CMHTs - Percentage of referrals categorised as crisis/emergency that are assessed within 4 hours** - performance has deteriorated particularly in the last 12 months. Based on the data reported by the Trust there is a downward trend in number of crisis referrals received by the service. There is a similar trend for the number of referrals assessed within the agreed timeline. Exception reports are provided monthly to explain non-delivery of this KPI.

- **Adult CMHTs - Percentage of referrals categorised as urgent that are assessed within 7 calendar days** – this KPI has not been achieved since Nov 2016 apart from 3 occasions during Y2 of the contract. Trend analysis indicate no change in number of urgent referrals being received by the service however there is a downward trend in number of patients being assessed within the agreed timescale. Exception reports for this indicator have not been consistent over the period of contract delivery.

- **Adult CMHTs - Percentage of referrals categorised as non-urgent that are assessed within 28 calendar days** – performance for this KPI has deteriorated since the end of Y1 of the contract (Aug 16). Trend analyses indicate that the number of non-urgent referrals has increased however the number of referrals

assessed within the agreed timescale has decreased. Exception reports for this indicator have not been consistent over the period of contract delivery.

- **Part 1 and Part 2 summaries should be issued to the service user's GP within 10 days of discharge from care under this specification** – threshold of 95% was agreed since Apr 17 and only met on 3 occasions since then. Exception report was this KPI is not always comprehensive and a general feedback from the Trust is that non-compliance is due to admin staff availability.
- **% of service users who have had a comprehensive physical health assessment** – previously this KPI was measured based on the audit of 20 patient's notes. Threshold of 85% was agreed since Apr 2017 and since then it was achieved on 6 occasions. From Oct 2018 this measure is based on the caseload. When the measure was changed from an audit of 20 to electronic caseload it was acknowledged it will take OHFT 12 months to achieve compliance. Over the last 8 months very slow improvement has been made. OHFT is working on improvement plans.

Contract development and initial delivery faced some significant challenges including contract mobilisation, finalising definitions of Incentivised Outcomes and KPIs used to measure them. IT systems needed to be updated and upgraded to allow for data capture and extraction to evidence Outcomes and Local Quality Standards achievement. There are still some outstanding challenges which need addressing and include MH service provision for patients with ASD and ADHD.

On the whole, good progress has been made and it is recommended for the outcome contractual arrangements to continue. Based on the last four years of experience we would like to make some recommendations which are listed below.

The reflections on the desktop review are:

- Use MHSDS to monitor referrals, activity, caseload, discharges and other performance measures. Data Quality Improvement Plans are currently being finalised in order for this data set to be of very high quality.
- Demand and capacity tool – as currently being developed by OHFT to be used to better manage and understand demand but also to identify potential efficiencies and pathway adjustments.
- The requirement for OHFT to provide regular information around capacity including number of vacancies, bank and agency staff.
- Crisis pathway and home treatment team to be funded and included within this contract
- Flexibility to adapt requirements of the national directives of NHS Long Term Plan e.g. PCNs
- To clarify and address needs of patients with ASD and ADHD.

8. Financial review

Initial annual contract value for 2015/16 was £36M. As per the national guidance, national net inflator of 0.1% was applied in 2018/9 and 2.6% in 2019/20 bringing the total contract value to £43M in 2019/20. National net inflator and other specific investment agreed between OCCG and OHFT contributed to the overall year on year increase in contract value.

The Council's annual contribution has remained at £6.2m to the OBC over the life of the contract. A further contribution of £1.8m is made by the Council to OH for the S75 social work staffing under a S75 agreement which is separate to the OBC.

The subcontracts between OH and the third sector providers were set up as flat cash and the review shows that there has been no increase in funding for the sub-contracted services delivered in the OBC since the start of the contract in 2015 despite an increase in the overall contract value as detailed above.

This exercise has provided transparency about the position of the sub-contracted partners of the OBC who continue to value their role in the partnership and the opportunities that it creates. All of the third sector partners appear to be in a stable financial position and the number of people supported through those organisations has increased over time indicating a strengthening of the mental health sector locally. However, it is clear that the stable financial position of third sector partners is largely due to income generated through fundraising or other income-generating activity and consideration should be given to how tenable this is going forward.

It should be noted that financial deficits for providing the services in the OBC continue and in 2018/19 all third sector organisations, bar one, had their highest deficit. A review of 2018/19 published accounts (when available) should take place to ensure that the organisations overall position in terms of stability remains unchanged, as a declining financial position will affect staff retention.

OHFT do not routinely report the position for the OBC in isolation to the wider position for the organisation. To improve transparency, reporting mechanisms need to be put in place to enable a more holistic on-going overview of the overall OBC contract and Provider Pool and any review of the financial position should include all spend within the OBC as the activity inter-relates.

The continued increase in spend on residential social care is unsustainable. Although further work is needed to understand this fully, it is understood that the Supported Independent Living pathway needs to work differently. As the lead contractor OHFT should work with their sub-contracted partners to understand whether existing service provision can be developed to reduce these costs.

The review highlights the additional funding from OHFT to the third sector for services provided to support the OBC, however the relationship between these financial flows and the contractual arrangements for the services, requires further clarity.

The third sector partners in the OMHP have been consulted and would like to make the following points:

1. We signed up to a flat contract when the Most Capable Provider came out, albeit with all parties to OMHP having some reservations at that time in particular on the 'flat rate' nature of the contract.

2. There have been various developments and changes since then, reflected in our submission. Some of the commitments in the submission (for instance closing a ward) have not been met. On the other hand progress on the outcomes and resulting Key Performance Indicators has been strong, and we have coped with a significant increase in demand for services in the OMHP across the board that was not anticipated at the time of the submission.

3. The context of the Shipman report has been to build a sense across the whole commissioner / provider system that there is a need for more funding – we see this as a systemic issue, not one related to one partner/group of partners over any other. A number of factors have contributed to this situation:

    - The increase in demand for services
    - Other cuts to services in the broader system
    - Inflationary pressures on costs incurred in providing services (cost of living, property, etc) in the framework of a flat contract value. Our understanding is that there have been profound financial difficulties for OH and although we had hoped for and put a strong case for some uplift, this has not been possible.

4. All Partners (NHS and Third sector) are in the same position – we all spend more money on providing OMHP services than the income we receive

5. The difference is made up in contribution from a number of sources:

    a. Fundraising and grant income (from the Third sector)

    b. Reserves and/or deficits

9. What next?

National mental health policy has moved on since the start of the OBC contract. In the last three years NHS England has published the *Five Year Forward View for Mental Health* and the *NHS Long Term Plan*. We now know that targeted funding will be available to specific sites for a range of initiatives and pilots in adult community mental health including:

- Funding for the development and testing of **maternity outreach clinics** in 2020/21 and 2021/22 ahead of national roll-out;
- Funding to pilot **new models of integrated primary and community care** for adults and older adults with severe mental illnesses in 2019/20 and 2020/21.
- Continuation of funding for **mental health liaison services** to achieve 70% coverage of 'core 24' services by 2023/24;
- Continuation of the **Individual Placement and Support (IPS)** wave funding in 2019/20 and 2020/21;

- Testing of **clinical review of standards** in 2019/20;
- Developing a hub and spoke model for **problem gambling** from 2019/20, with central clinics which have satellite clinics in neighbouring populations;
- Completing the piloting of **Specialist Community Forensic Care** and women's secure blended services by 2020/21;
- Implementation of **enhanced suicide prevention** initiatives and bereavement support services;
- Developing new mental health services to **support rough sleepers**, to meet the ambition of the Government's rough sleeping strategy for the NHS to invest up to £30 million over the next five years in this area.

(NHS England, 2019)

All of these priorities need to be considered by the partnership, but essentially it is the partnership's role to respond to the needs of local people and to shape services to meet all the outcomes which have been set.

10. Conclusion and recommendations

The Oxfordshire OBC partnership has been quick off the blocks in trying a new way of working together to achieve better mental health for local people. Oxfordshire has pioneered the model of outcomes based commissioning in mental health and commissioners and providers should be congratulated for stepping out on an unknown and long road, for which no one had a map.

Oxfordshire benefits from a strong third sector and the availability of new services including a crisis café and recovery college, and a commitment to improving physical health. These things are certainly not in evidence in all other areas. The OBC also presents the opportunity for new thinking on care solutions, to provide the right help for more people without putting them elsewhere for care or making them wait for a long time.

The recommendations made by Centre for Mental Health are:

Recommendation 1

The OBC partnership as currently constituted should continue. As the Partnership matures, and once the financial situation in the local health and care economy and demand for mental health care have both stabilised, it may then be well placed to take the opportunity to re-design an effective and comprehensive mental health care pathway.

Recommendation 2

The partnership should agree where revised contract targets would help to drive up performance (or costs savings) against the outcomes and hold each other to account for the expected results. The partnership should seek new or existing partners willing to develop

services which will reduce spot placements and therefore reduce costs, review out of area placements and meet needs that are not currently being met.

Recommendation 3

The OBC partnership and the commissioners should identify resource for commissioning support to ensure the partnership is fit for its ambitions, and to align closely with the recommendations of national and local mental health policy.

References

NHS England, 2019. Long Term Plan. Available from https://www.longtermplan.nhs.uk/wp-content/uploads/2019/06/long-term-plan-implementation-framework-v1.pdf

Stephen Chandler Corporate Director of Adult Services

Background papers: None
Contact Officer: Eleanor Crichton Oxfordshire County Council
(Section 75 Mental Health Social Work)

February 2020

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Division(s): N/A

PERFORMANCE SCRUTINY – 4 February 2020

Delayed Transfers of Care & Reablement Service

Report by– Corporate Director for Adult Services

Recommendation

1. The Committee is RECOMMENDED to note the report.

Executive Summary

2. This report provides an overview of Delayed Transfers of Care (DToC) in Oxfordshire. It includes recent performance compared nationally and locally as well as a summary of the challenges facing the Health & Social Care System that have on impact on DToC performance.

3. Oxfordshire is one of the worst performing systems in the country in terms of DToC consistently ranking in the bottom quartile nationally, and for the current financial year is ranked 147th out of 149 authorities1. It is recognised that being delayed in hospital has a detrimental impact on a person's health and wellbeing. It is therefore critical that Oxfordshire's health & social care system partners work together to improve on recent poor performance in this area.

4. There are a number of challenges which impact on this performance, some of these challenges are being experienced by systems across the country, whilst others are specific to Oxfordshire. These are described in this paper as well as work that is underway to mitigate these challenges. As requested by the Performance Scrutiny Committee there is a specific focus on Reablement.

Definition of DToC

5. A delayed transfer of care (DToC) occurs when a patient is ready to go home and is still occupying a hospital bed.

6. A patient is considered as being ready to go home when all of the following three conditions are met:

- a clinical decision has been made that the patient is ready for transfer home
- a multidisciplinary team (MDT) decision has been made that the patient is ready for transfer home
- the patient is considered to be safe to discharge/transfer home.

[1] South East Region Datasets - DToC Performance Analysis 01.04.2019 - 30.09.2019

7. Delays are reported based on the reason for the delay e.g. awaiting care at home, awaiting a care home etc. In addition, the organisation responsible for the delay is recorded meaning they can be attributed to the NHS, social care or both social care and the NHS.

8. In Oxfordshire, delays attributable to both social care and the NHS include those people waiting for reablement support on discharge. This is because Oxfordshire's reablement service is jointly commissioned by the County Council and Oxfordshire Clinical Commissioning Group and provided by Oxford University Hospitals NHS Foundation Trust.

9. Figures on delayed transfers of care are published on a monthly basis by the Department of Health (a month in arrears).

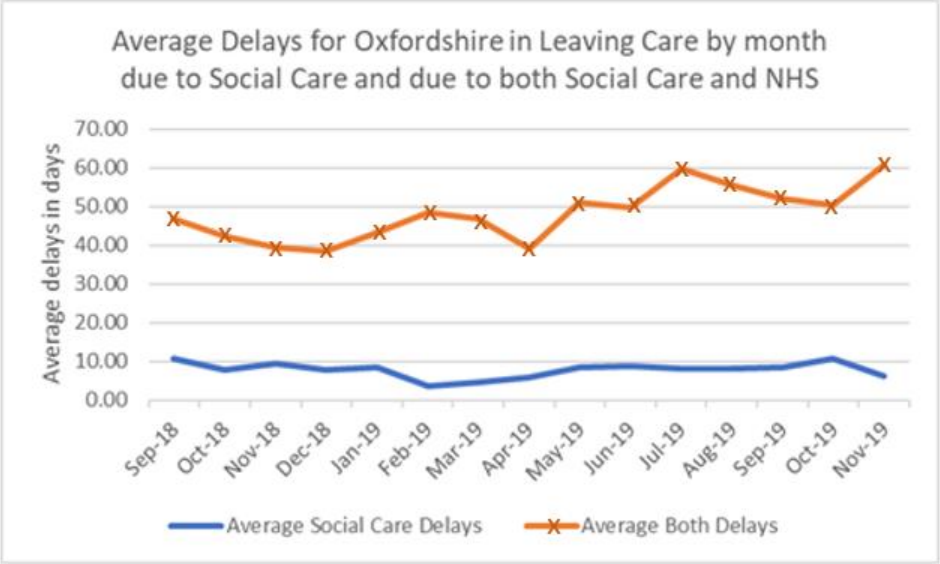
Performance

10. Historically, Oxfordshire has struggled with delayed transfers of care. Whilst the total number of delays over the last few years have reduced, they remain at an unacceptable level, resulting in people remaining in hospital longer than they need to. More recently over the summer of 2019 there has been an increase in the levels of delays which resulted in the DTOC indicator moving from amber to red in the July performance report.

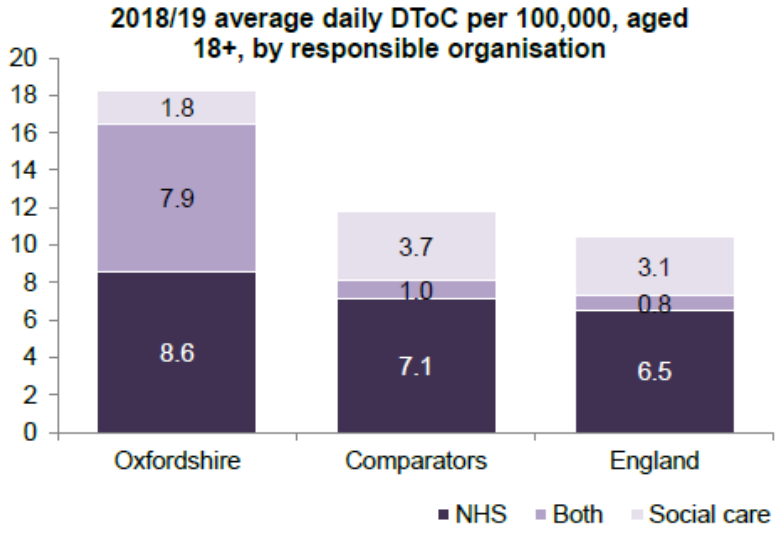
11. Delayed transfers of care impact upon the flow of people through the health and social care system, and results in hospital beds being occupied by people who could be cared for out of hospital. Remaining in a hospital bed longer than is clinically required has a detrimental impact on people's health and wellbeing, with the effects of this being most severe for older people. It is reported that ten days in a hospital bed can lead to the equivalent of 10 years ageing in the muscles of people aged over 80. Therefore, people's health, wellbeing and ongoing care needs are negatively impacted by delayed transfers of care.

Recent Performance

12. The graph below shows the average number of people delayed leaving hospital each month. This is split into delays attributable to 'Social Care' and to 'both Social Care & NHS' (September 2018 – November 2019).



13. Currently the 'both' delays far outnumber delays which are attributed to social care. This reflects the challenges that Oxfordshire experiences in relation to capacity and flow within the reablement service.



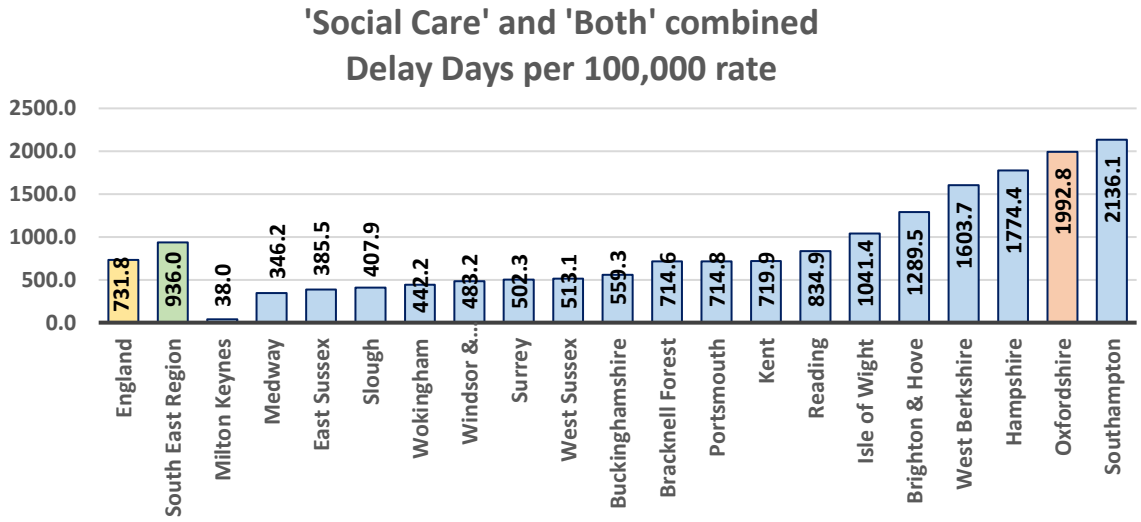
Comparison with other authorities

14. When compared nationally Oxfordshire has consistently ranked in the bottom quartile of authorities in England when looking at the total number of delayed transfers of care.

15. Regionally Oxfordshire ranks as the second worst authority for delays attributed to "Social Care" or "Both Social Care and NHS". The graph below shows this comparison in terms of the "number of delay days per 100,00 population. The figures are based on the total number of delay days from 1

April 2019 to 30 September 2019[2], averages for the South East region and England are also given for comparison.

16. It is important to note that while the authorities listed are geographical neighbours, they are not necessarily comparable to Oxfordshire in terms of size and structure.



Local challenges impacting on performance

17. Below is a summary of the challenges facing the Health & Social Care System that have on impact on DToC performance:

Availability of care

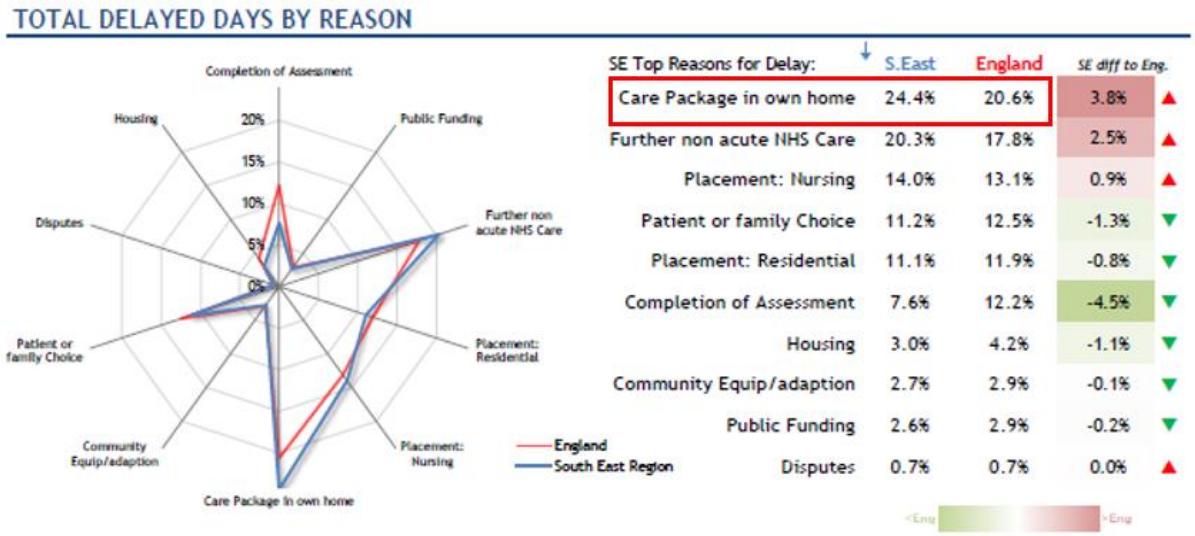
18. The key issue for the recent increase in delays is the available of care, particularly homecare.

19. The table below highlights the percentage of attributable delays in Oxfordshire

[2] Figures are taken from the South East Region Datasets - DToC Performance Analysis 01.04.2019 - 30.09.2019.

Reason for Delay	Total
Care Packages in own home	50.6%
Further non-accute NHS Care	19.3%
Patient or Family Choice	10.8%
Completion of Assessment	8.5%
Placement:Nursing	4.3%
Housing	3.4%
Placement: Residential	1.8%
Community Equipment/Adaptation	0.6%
Public Funding	0.5%
Disputes	0.2%
Other	0.0%

20. As the chart[3] below shows this is an issue across the South East and the rest of England, although not to the same extent as in Oxfordshire.



Workforce

21. Health & social care providers in Oxfordshire report significant difficulties in recruiting enough care workers. We also know that there is a high turnover of staff within the sector, with home care providers in particular reporting challenges regarding recruitment and retention.

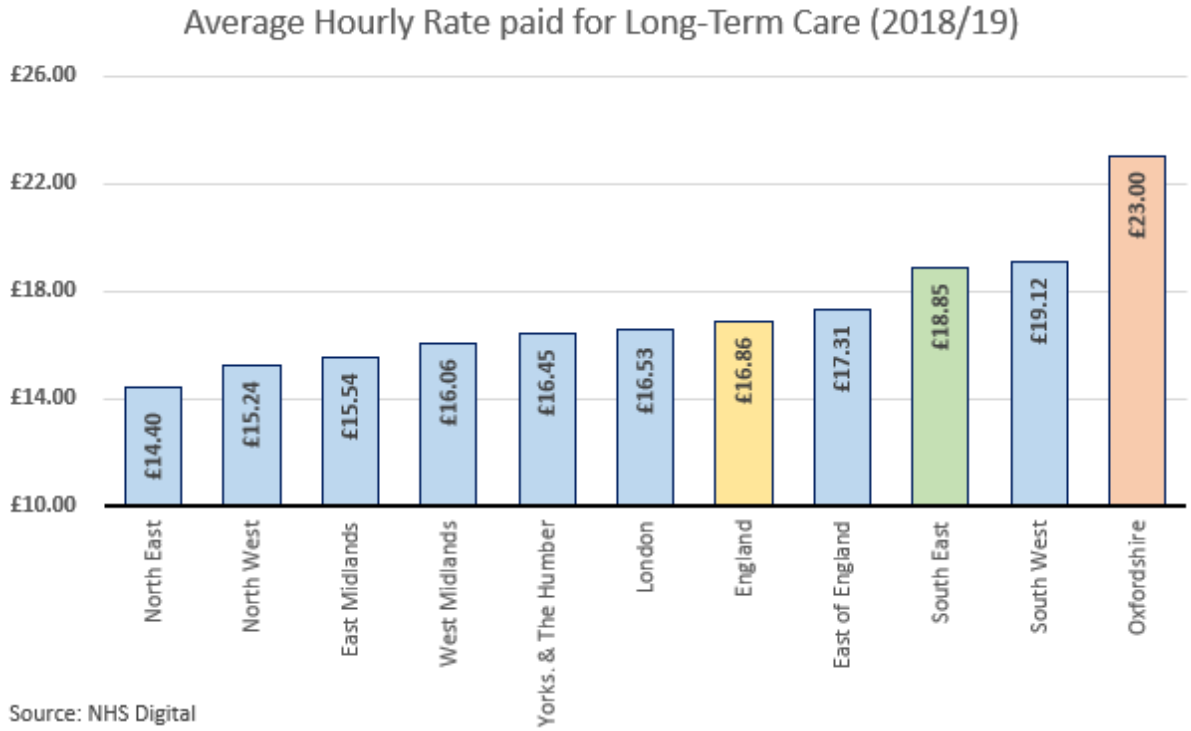
22. Workforce challenges are linked to the low levels of unemployment in Oxfordshire, with the relative economic buoyancy bringing employment opportunities in other sectors. Also, Oxfordshire is one of the least affordable places in the country to live. In 2017, Oxford was ranked as the most expensive city in England to buy a house (comparing average household income) and the third most expensive place to rent. Lack of affordable housing is a major issue in recruitment and retention of staff which is reflected

[3] South East Region Datasets - DToC Performance Analysis 01.04.2019 - 30.09.2019

in ‘Home Truths 2017/18’, a report produced by the National Housing Federation that provides local data on the housing market in the South East.

23. Oxfordshire County Council is nationally regarded as paying higher amounts for care, with the resulting position that care providers can pay attractive rates for staff. In May 2018 the average hourly cost of long-term care[4] purchased by the Council was £23.22, this rose to £24.33 by December 2019 an increase of 4.75% in 19 months. For comparison the hourly rate the UK Home Care Association propose as the minimum price for homecare from April 2019 is £18.93.

24. The chart below shows the average rate paid for long-term care by the Council in 2018/19 compared nationally.



25. In spite of these high rates of pay recruitment and retention of staff remains a challenge.

26. This workforce challenge is unlikely to diminish with recent projections indicating that, over the next ten years we will need to grow our workforce by 35%-55% in order to meet the increasing demand.

27. In addition between 2015 and 2030, the number of people in Oxfordshire aged 85 and over is expected to increase by 95%. Oxfordshire also experiences a higher demand for services than you would expect from the demography.

[4] “long-term care” figures include all hourly paid home care including those provided in Extra Care housing settings, those provided by traditional care agencies and contingency care provided by OH/OUH following reablement

28. This represents a significant challenge, particularly in the context of Oxfordshire's high-wage, high-skills and low unemployment economy.

Seasonal variance

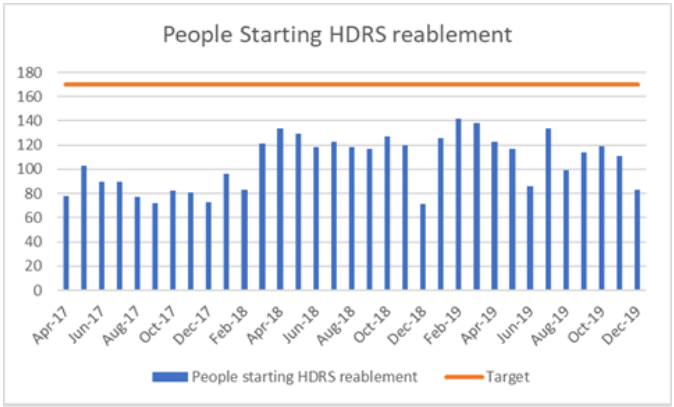
29. The Oxfordshire health & social care system experiences seasonal variances in relation to the need for care and support, and the availability of care provision. For example, higher levels of acuity and risk may be reported during winter months and the social care workforce is affected

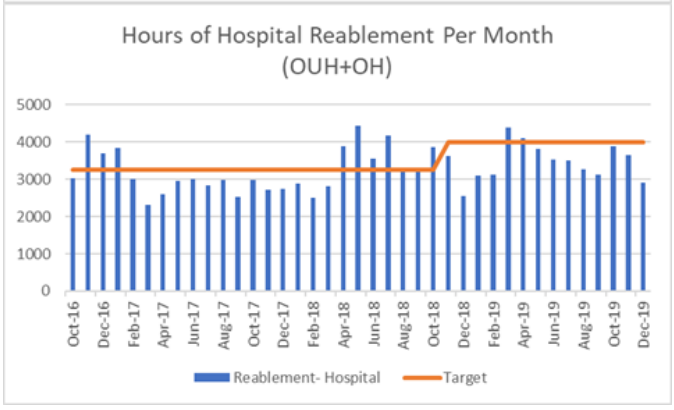
30. Capacity levels in the homecare market in Oxfordshire have been particularly low for the months of July and August. This is a recurrent yearly problem and is mainly due to the predominantly female workforce, school holidays and childcare issues.

Reablement

31. As well as being affected by the recruitment challenge described above, the reablement service also has issues with both the supply and package size of people receiving reablement.

32. The graph shows the number of hours of reablement provided each month against the target. Whilst in some months the service was able to deliver higher than the targeted number of hours this did not necessarily translate into an increased number of people starting reablement as those individuals were receiving more reablement care then we would have predicted when the contract was initially set up.





Actions the System is taking

Reshaping the Home Care Market

33. It is clear that given our challenges with workforce we need to reshape the way we work with our care providers. The Home Care 2021 project has been created to develop a new partnership model and a new business offer for Home Care provision. We need do things differently, including improving how we work in partnership and address the opportunities and challenges within the sector.

34. This is a significant opportunity to co-design a new home care model and contract offer. This is being done by working collaboratively with key stakeholders to achieve positive outcomes for Oxfordshire. Working together, we aim to build a new model that:

- Delivers a stronger partnership approach with Providers
- Utilises system wide capacity effectively and improves flow across health and social care
- Has a stronger focus on outcomes for people who are receiving care
- Delivers value for money, is financially sustainable and provides opportunities for the workforce
- Has Co-Production with key stakeholders at its heart.

Implementing Strengths-Based Approach

35. A strengths-based approach to care is a collaborative process that draws upon an individual's strengths and assets and those within their community. When working with the individual to design a plan which meets their needs, we will look at their strengths, both personal and in their community before looking at formal care services. This should lead to support plans which contain more community and technology-based services and fewer formal care services such as home care.

36. Providing better outcomes, should enable people to stay independent, resilient and well for longer. It encourages a more effective use of our services and mitigates the problem of revolving door admissions. Staff across all Adult Social Care Teams are taking part in a practical coaching, learning and development programme on strengths-based approaches. As of November 2019, over half of all practitioners have graduated from the programme. The rest are expected to graduate by March 2020. At that time, we would expect all interactions with the service to utilise a strengths-based approach.

Review of Care Home Provision

37. In 2019, the Council and Oxfordshire Clinical Commissioning Group, supported by Oxford University Hospitals (OUH) and Oxford Health (OH), led a review of all short stay care home beds, many of which were used to support people on discharge from hospital. A new model for short stay care home beds has been developed to support people on discharge from hospital in situations where they may require further rehabilitation or recuperation or where ongoing care arrangements are being put in place.

38. Through this model, it is intended that people can be supported to leave an acute bed in a timely way by utilising contractual and partnership arrangements with care homes. Support services are in place to support these beds, to ensure that people can leave their short stay bed when they are ready to do so.

39. In addition, as part of the regular reviews of services and strategies it became clear that there was a significant opportunity in the care home sector to maximise efficiencies with providers whom we have significant spend.

40. The aim of the review is to ensure care homes contracted by OCC and OCCG have the capacity and capability to meet the needs of residents. Specifically it aims to:

- Determine the best procurement and contractual approach, to deliver the right number of beds in terms of scope, geography, specialism and price
- Maximise the impact of the care delivered in care homes to support good patient outcomes, system resilience and flow

41. Alongside this it is important to note that whilst undertaking this work we need to maintain the choice and quality of services for all Oxfordshire residents.

42. The development of a strategic plan is underway and is due to be discussed by the Joint Management Group in the New Year.

New Approach to Urgent Care

43. The Oxfordshire Health & Social care system is developing a new approach to urgent care, with leadership provided by OUH and OCC. This is in recognition that urgent care capacity and pathways require sufficient capabilities and support from community-based services, to help avoid unnecessary admissions and support people to return to their homes when they no longer require acute support.

Reablement Service

44. As requested reablement is covered in more detail in the following section.

Reablement

45. Reablement is a short and intensive service, usually delivered in the home. It is offered to people with disabilities and those who are frail or recovering from an illness or injury. The purpose of reablement is to help people who have experienced deterioration in their health or an increase in support needs to relearn the skills required to keep them safe and independent at home. People using reablement experience greater improvements in physical functioning and improved quality of life compared with using standard home care.

Reablement Contracts

46. There are currently two contracts delivering reablement in Oxfordshire:

- **Hospital Discharge and Reablement Service (HDRS)** – Discharge to assess (D2A) supports people to leave hospital, when it is safe and appropriate to do

so. It enables them to continue their care and be assessed for their longer-term needs in the right place.

- **Community Reablement Service (CRS)** – this covers reablement in the community

47. Both contracts include a contingency element, which is used if a person reaches their reablement potential but requires ongoing support. The service is expected to provide this until a long-term provider is sourced by utilising the contingency home care hours in the contract. The contract was explicitly commissioned with a large amount of contingency home care to support discharge, with the aim of improving flow through the system and reducing delays earlier in the pathway.

48. Oxford University Hospitals NHS Foundation Trust (OUHFT) hold both contracts, using a service called Home Assessment Reablement Team (HART). OUHFT sub-contract a specific geographical region of the county to Oxford Health NHS Foundation Trust (OHFT) who deliver these using a service called Community Care Support (CCS). The geographical split is shown in the map below.

49. As discussed above, the reablement service is not currently supporting the expected numbers of people and those that do receive the service may still experience delays in the arrangement of ongoing care.

Monitoring Reablement Performance

Contract monitoring

50. Contract monitoring meetings are held by the OCC Contracts Team with the reablement providers on a monthly basis. The contractual key performance indicators (KPIs) are reviewed and actions for improvement agreed. The contractual KPIs are shown in Annex 1.

Combined monthly dashboard

51. A dashboard of 15 key measures is produced and distributed to key stakeholders on a monthly basis. There is some crossover with the contractual KPIs and the measures are:

1. The number of patient episodes supported in month
2. Total hours delivered
3. Average number of contingency patients
4. Support Worker Whole Time Equivalents (WTEs)
5. New patient pick-ups in month
6. New hours picked up in month
7. Average number of weekly contingency hours
8. Percentage patient contact time
9. HDRS reablement average package size
10. CRS reablement average package size
11. DToC attributable to Reablement & Contingency
12. In month staff sickness hours lost
13. Percentage completed reablement episodes discharged with no ongoing care
14. Percentage completed reablement episodes discharged with reduced care needs (inc. no ongoing care)
15. Discharge to Assess Project – percentage net reduction in hours at discharge for in month discharges

52. Annex 2 contains the latest combined monthly dashboard (October 2019).

Actions to improve Reablement Performance

53. In August 2019 HART & CCS presented a Joint Assurance plan which was subsequently agreed by Oxfordshire Health & Social Care leaders. The plan consists of 6 sections:

1. **Prioritisation Protocol** – Implement a system-agreed joint prioritisation protocol to support the management of waiting lists that is linked to the system operational pressure escalation levels.

2. **Performance Dashboard** – Provide assurance to system leaders on reablement performance through a dashboard that clearly outlines key performance indicators against agreed thresholds and improvement trajectories.

3. **Performance Improvement** – Implement a therapy-led discharge to assess reablement service that maximises access to home-based goal-directed reablement aiming to achieve independent living and social re-integration.

4. **Leadership and Workforce Development** – Jointly develop and implement a workforce plan that aims to recruit and retain a highly skilled and capable reablement workforce.

5. **Maximising System Reablement Opportunities** – Ensure effective system contribution and appropriate use of resources to maximise reablement opportunities.

6. **Performance and Improvement Trajectories** – Identify improvement trajectories for ley performance measures describing the baseline and forecast positions.

54. In September 2019 key system leaders formed the HART Assurance Plan Delivery Board. Service leads present updates on delivery of the assurance plan on a monthly basis to provide assurance that the service is delivering on the plan. This includes the reporting of five KPIs:

- KPI 1: Improve the compliance of 3-day review
- KPI 2: Improve the compliance of 7-day review
- KPI 3: Improve the compliance ongoing weekly review
- KPI 4: No. of reablement hours provided per Month (inc. Welcome Home)
- KPI 5: Total HART hours to be provided per month

55. The latest Assurance Report is attached as Annex 3.

Stephen Chandler
Corporate Director for Adult Services

Contact Officer: Rachel Pirie

January 2020

Annex 1 – Contractual Key Performance Indicators

Key Performance Indicators - Hospital Dicharge and Reablement Service				
No.	**Indicator**	**Target HART**	**target OH subcontract 23%**	**Data Source**
1 - Hospital discharge maximised	Total number of hours delivered including assessments and contingency home care	75,000	17,250	Provider Returns & ETMS
	Total number of actual hours provided in monitoring period for the **Reablement Service** (target 39,000 hours pa)	**TARGET 3,250 hours per month**	**747.50 hours per month**	
	Assessment only - an additional 3,000 hours	**250 hours per month**	**57.50 hours per month**	
	Total number of actual hours provided in monitoring period for the **Contingency Home Care Service** (30,000 hours pa)	**2500 per month**	**575 hours per month**	
	Total number of actual hours provided in monitoring period for the **Welcome Home Service** (3,000 hours pa)	**250 hours per month**	**57.50 hours per month**	
	Total actual hours of above (75,000 hours pa)	**6,250 hours per month**	**1,437.50 hours per month**	
2 - Effectiveness of the Service	Of all the people who finish reablement (excluding those who died; were self funded or refused reablement) the proportion who had no on-going long term care needs (i.e. did not need council funded care home or home care) (See ASCOF 2D)	75%		Reporting from Service Provider discharge outcomes return
3 - Packages picked up within the timescale	% people receiving the Service who were picked up within the required response time (measured from when the referral is received to the start of the first visit). Response times are: 1 calendar day for hospital discharges and the same day for ambulatory care units.	97% response rate		Provider Returns, referral data & ETMS
4- Older People still at home after 90 days	The proportion of Older People (over 65 years) who are still at home 91 days after discharge from hospital into a reablement/rehabilitation service See ASCOF 2B(1)	85%		Provider to collect for three months (Oct, Nov, Dec)from Service Users
5 - Contact time	Percentage of contact time received by service users as a proportion of staff time	50%		Provider Returns & ETMS
6 - Increased Service User satisfaction	Increase in user reported level of satisfaction and user reported well being	to be agreed once year 1 base line established		Provider Service User annual survey)
7 - Increased Carers of Service User satisfaction	Increase in Carer reported satisfaction	to be agreed once year 1 base line established		Provider Carers Service User annual survey)
The Council reserves the right to revise these KPIs, or adjust the adjust the targets, or to introduce other KPIs using data collected from Providers or other data sources.				

Key Performance Indicators - Community Reablement Service					
No.	**Indicator**	**Targets for HART**	**Targets for OH sub contract at 23%**	**per week**	**Data Source**
1 - Hospital avoidance maximised	Total number of hours delivered including assessments and contingency home care	35,000	8,050		Provider Returns & ETMS
	Total number of actual hours provided in monitoring period for the **Reablement Service** (target 30,000 hours pa) City - 6,000 North - 12,000 South - 12,000	**2,500 per month**	**575 hours per month**	133	
	Total number of actual hours provided in monitoring period for the **Contingency Home Care Service** 5,000 hours pa)	420 per month	97 hours per month	22	
	Total actual hours of above (35,000 hours pa)	**2,920 per month**	**671 hours per month**	**155**	
2 - Effectiveness of the Service	Of all the people who finish reablement (excluding those who died; were self funded or refused reablement) the proportion who had no on-going long term care needs (i.e. did not need council funded care home or home care)	75%			Reporting from Service Provider discharge outcomes return
3 - Packages picked up within the timescale	% people receiving the Service who were picked up within the required response time (measured from when the referral is received to the start of the first visit). Response times are: 2 calendar days	97% response rate			Provider Returns, referral data & ETMS
4 - Contact time	Percentage of contact time received by service users as a proportion of staff time	50%			Provider Returns & ETMS
5 - Increased Service User satisfaction	Increase in user reported level of satisfaction and user reported well being	to be agreed once year 1 base line established			Provider Service User annual survey)
6 - Increased Carers of Service User satisfaction	Increase in Carer reported satisfaction	to be agreed once year 1 base line established			Provider Carers Service User annual survey)
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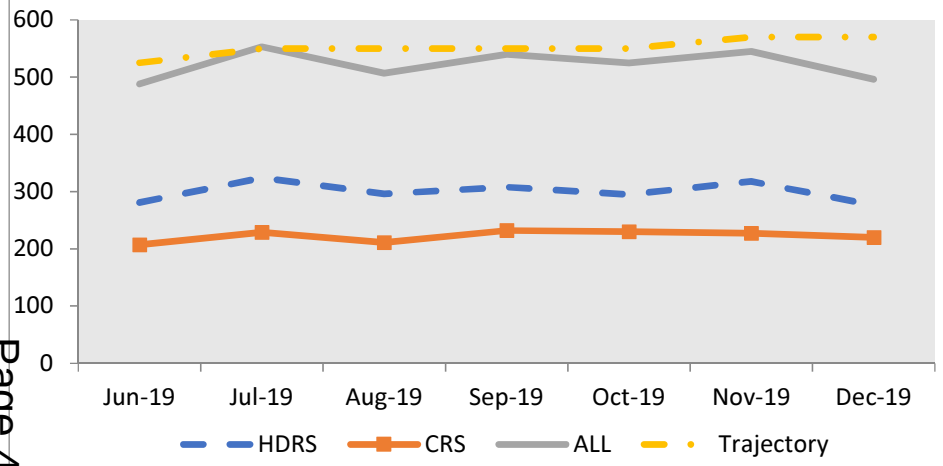
Annex 2 – OUH-OH Combined Monthly Dashboard December 2019

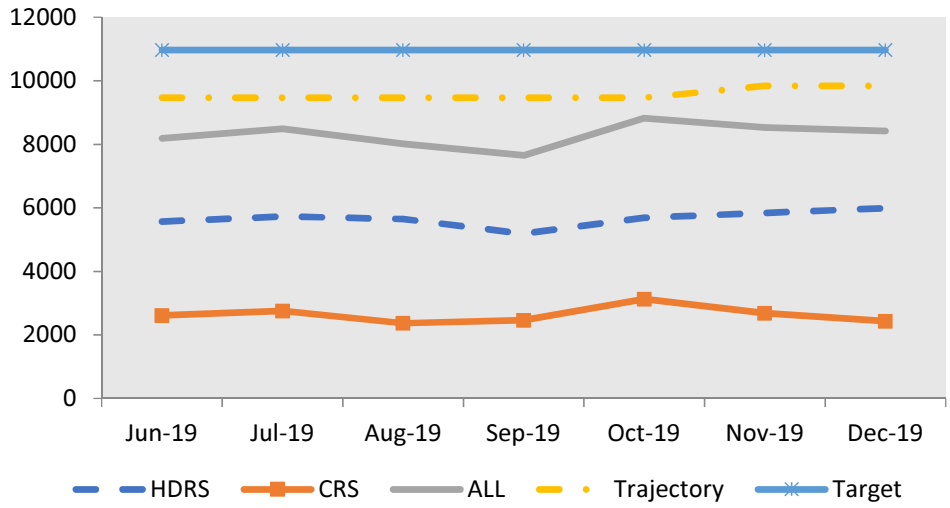
1.

Patient episodes supported in month HART+CCS combined



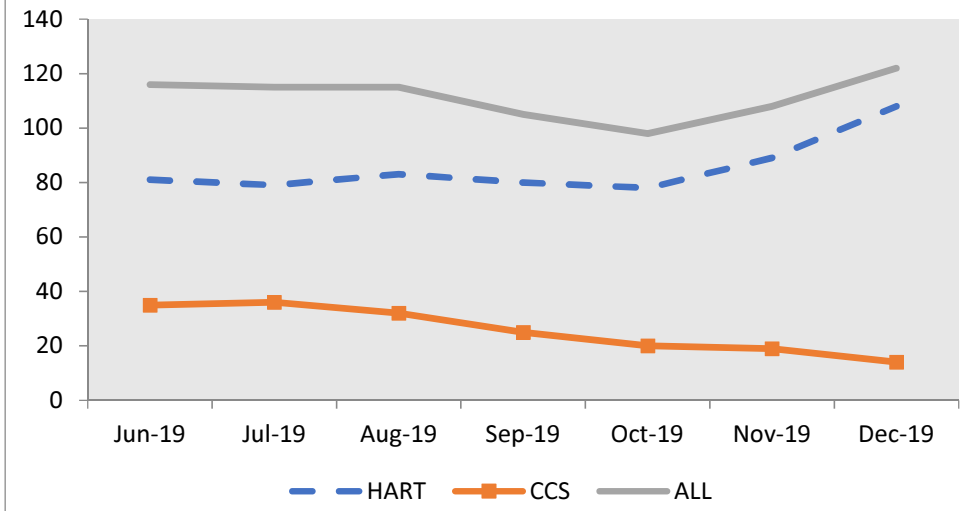
2.

Total hours delivered HART+CCS combined



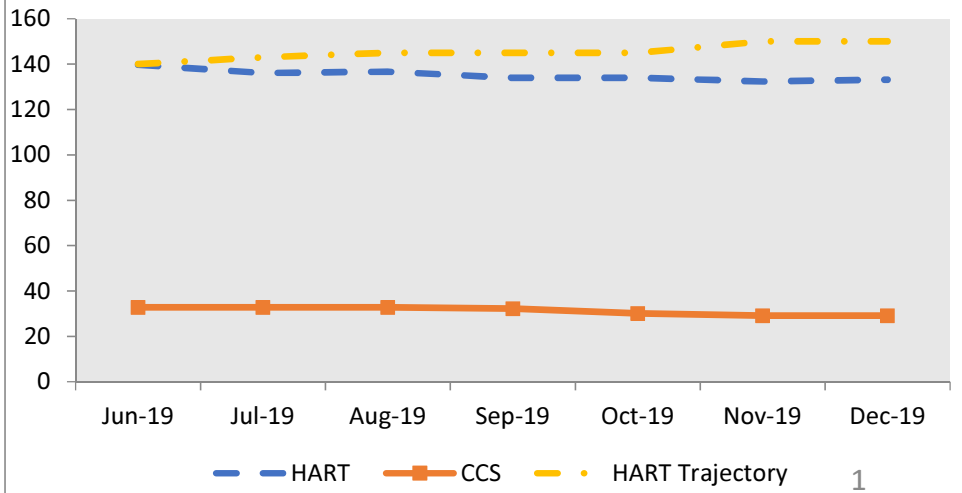
3.

Average Number of Contingency Patients



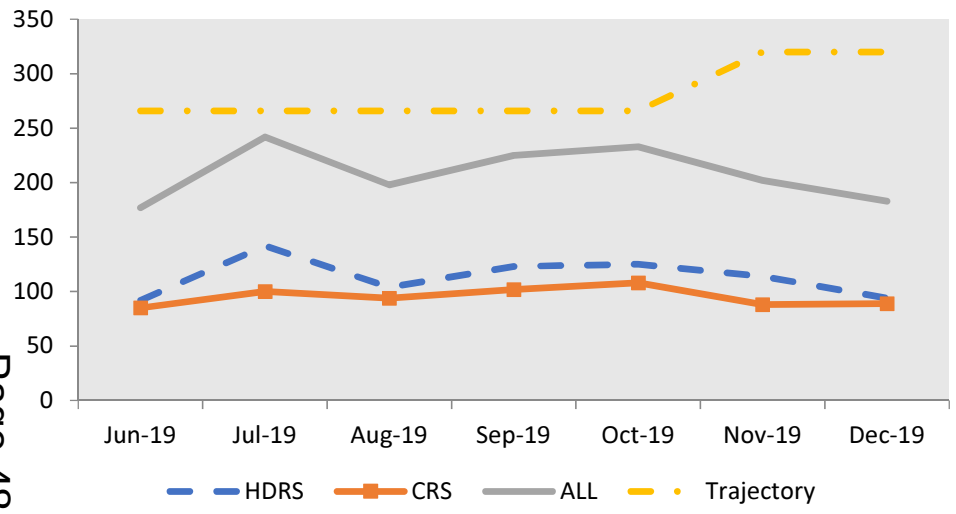
4.

HART Support Worker WTEs



Annex 2 – OUH-OH Combined Monthly Dashboard December 2019

5. **New patient pick ups in month - HART+CCS combined**



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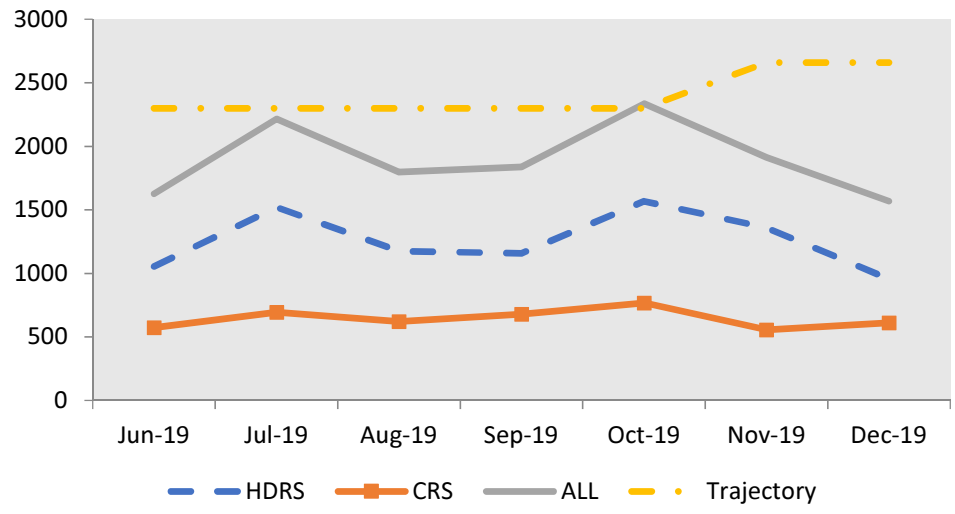
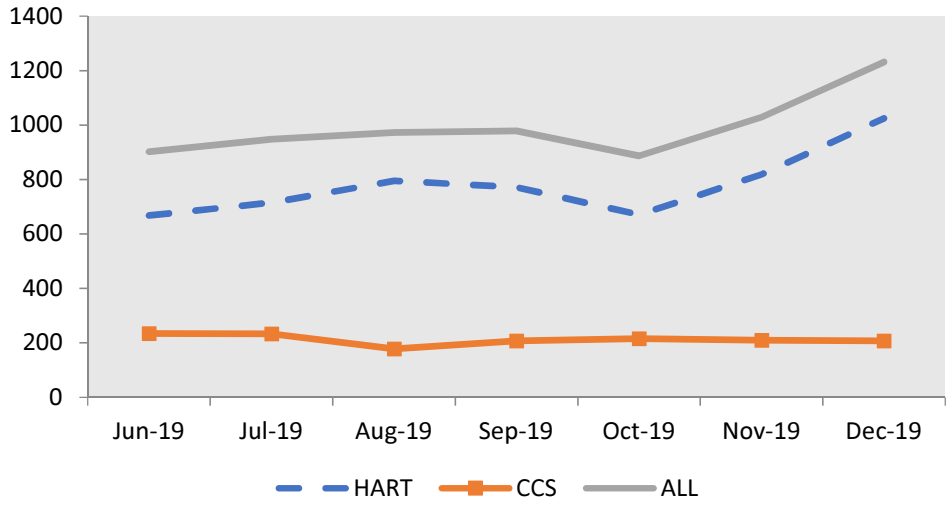
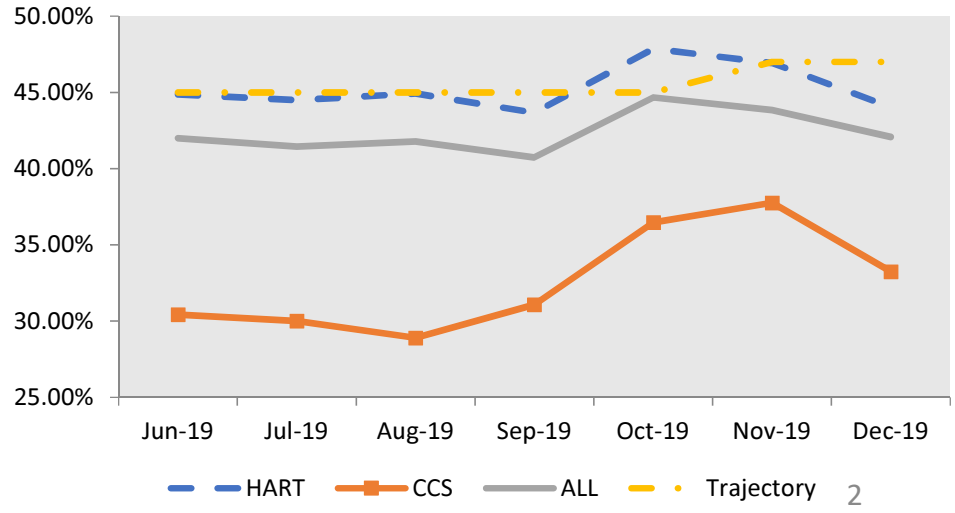


7. **Average number of Weekly Contingency hours**



8. **% Patient contact time**



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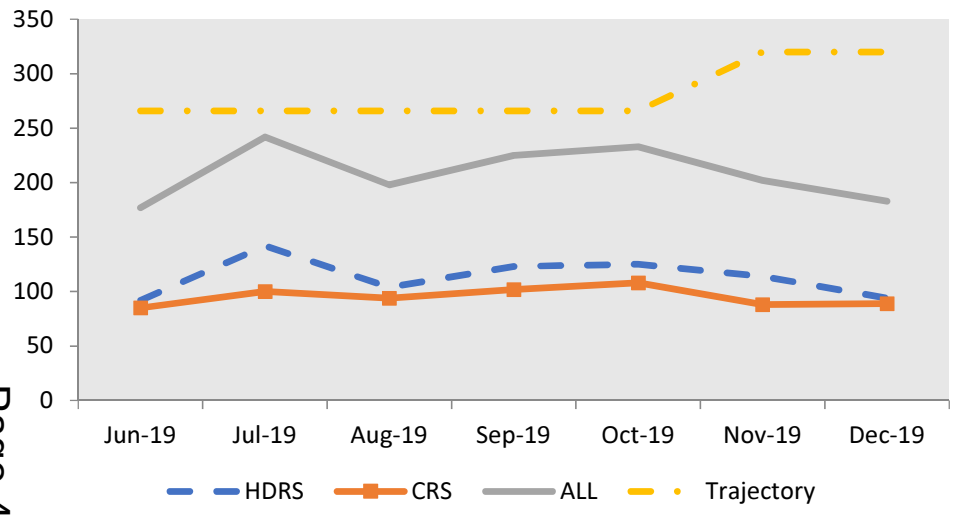

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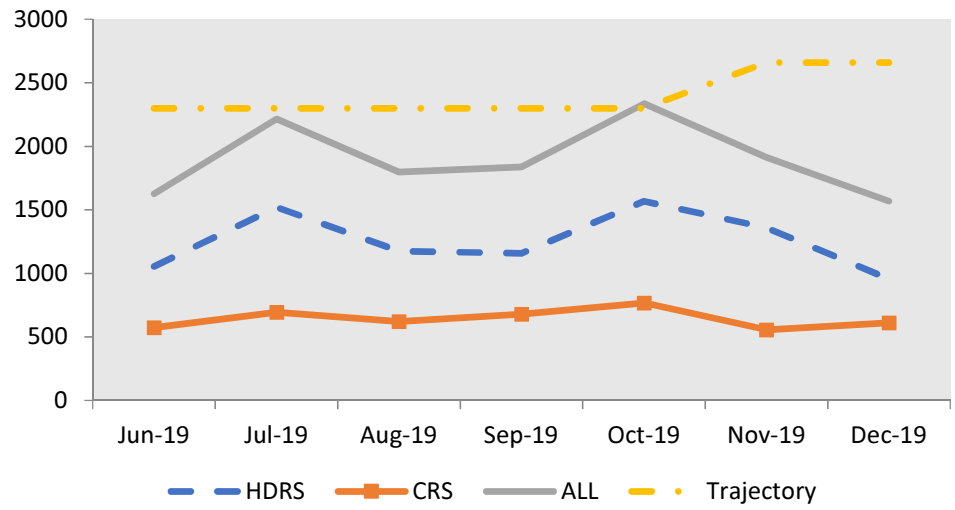

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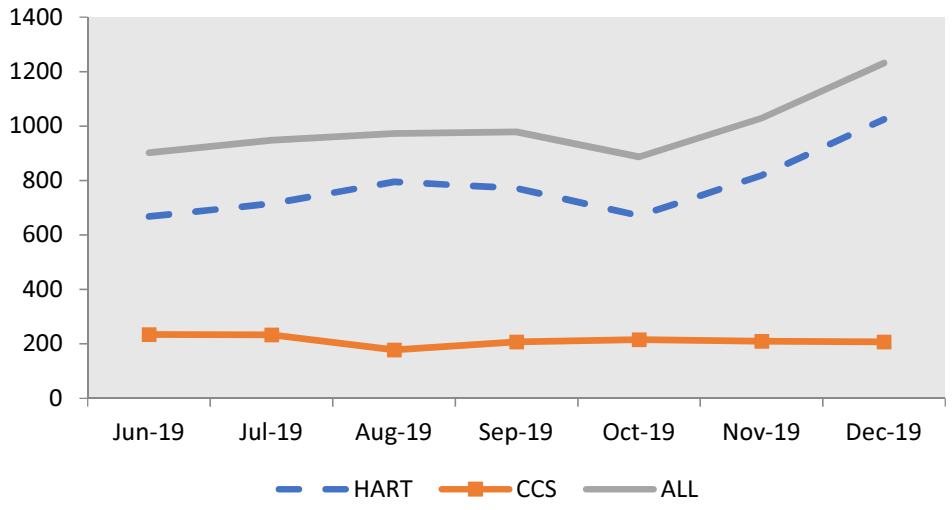
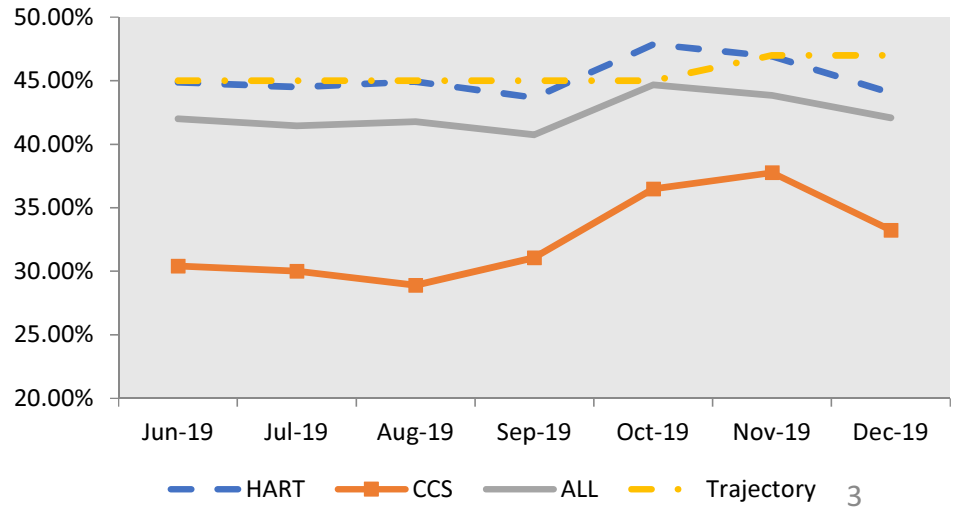
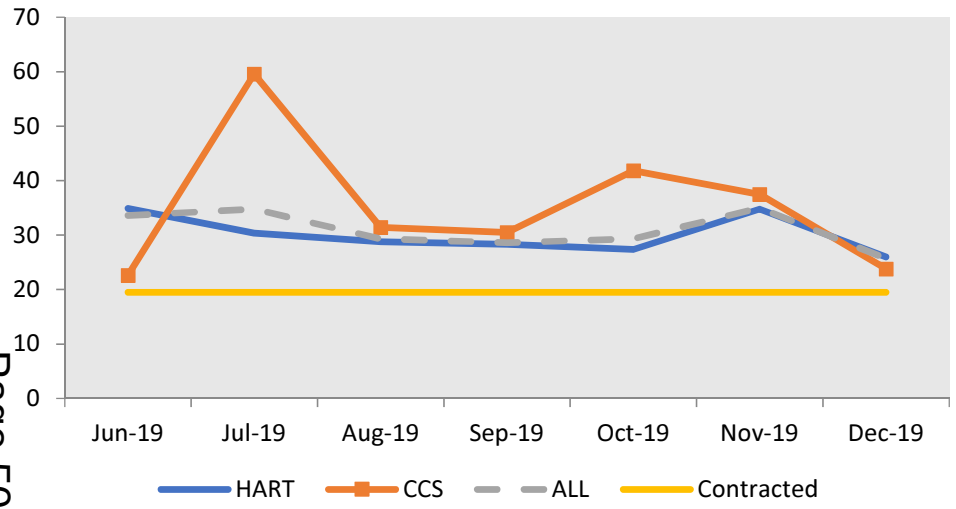


8. **% Patient contact time**

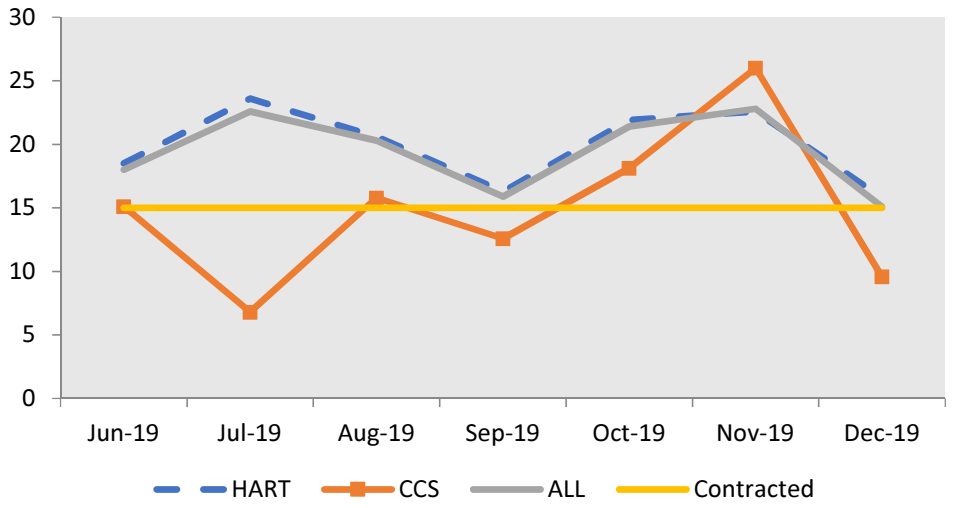


Annex 2 – OUH-OH Combined Monthly Dashboard December 2019

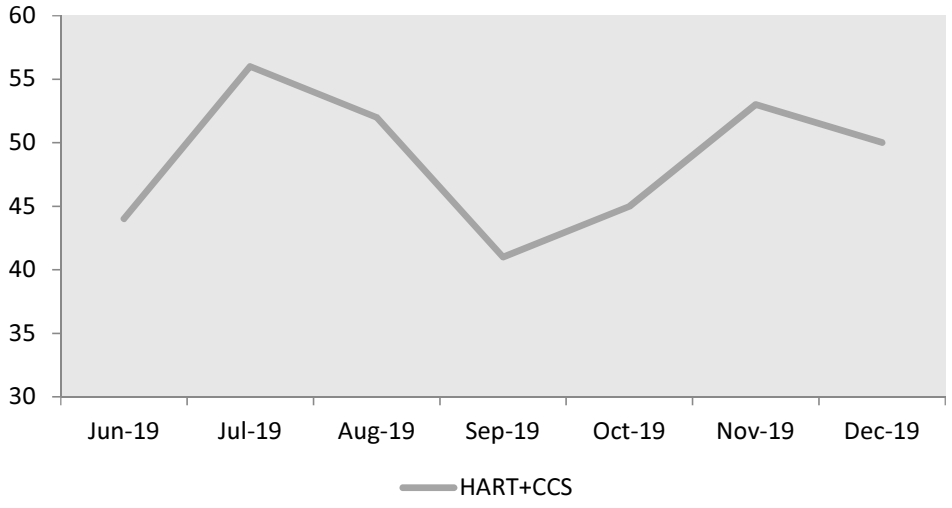
9. **HDRS reablement Average Package Size-hours**



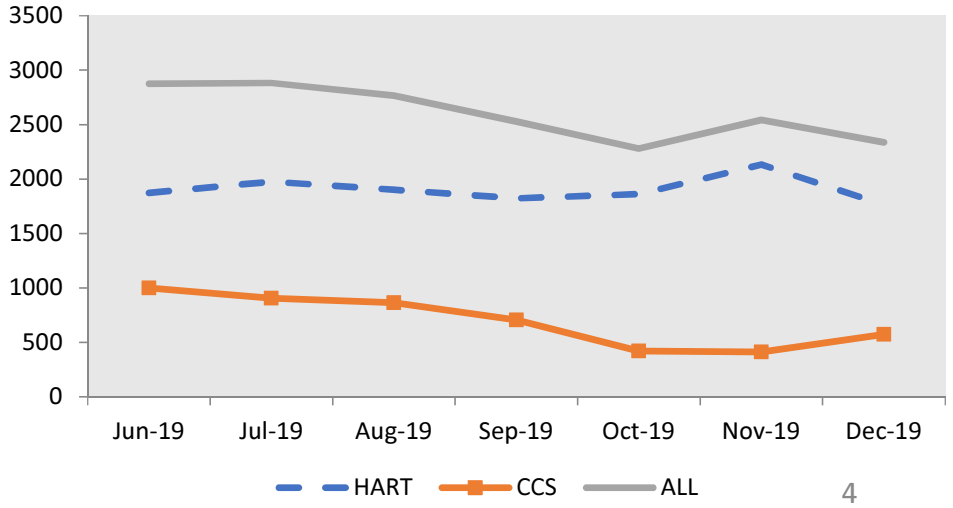
10. **CRS reablement Average Package Size-hours**



11. **E both (reablement and contingency) DTOC**

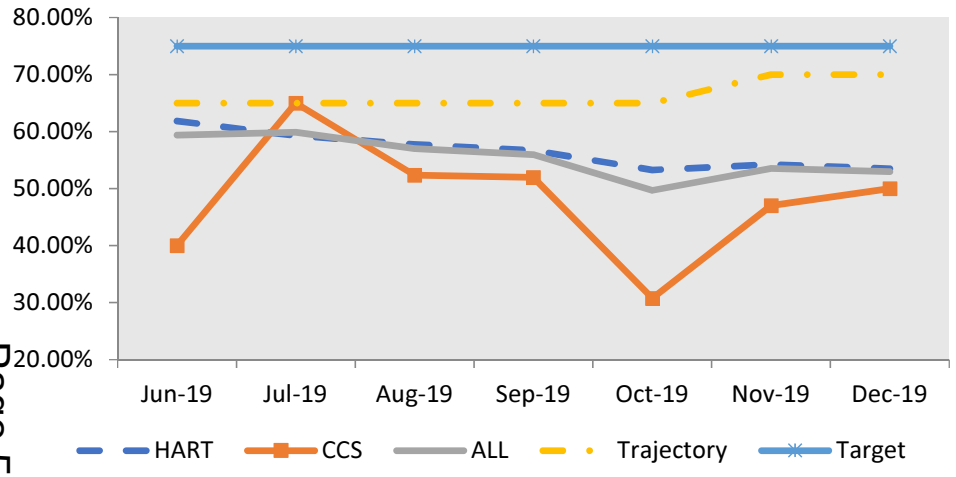


12. **In Month Sickness Hours Lost**

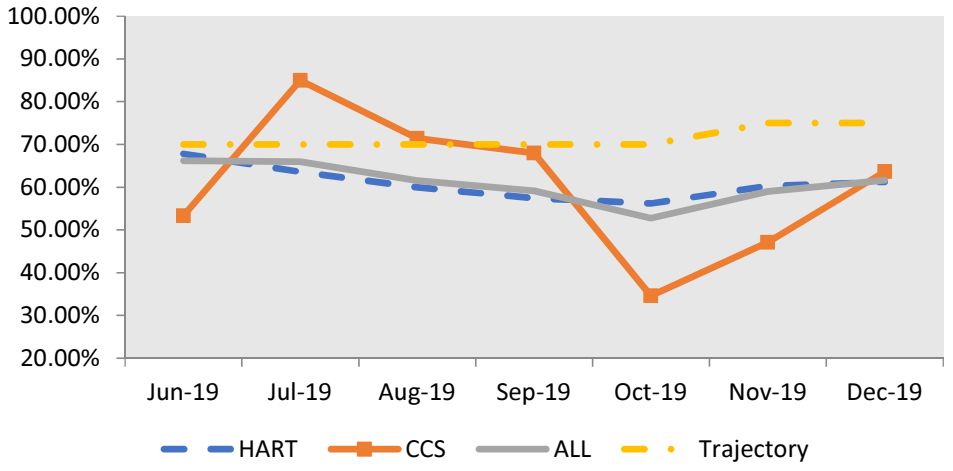


Annex 2 – OUH-OH Combined Monthly Dashboard December 2019

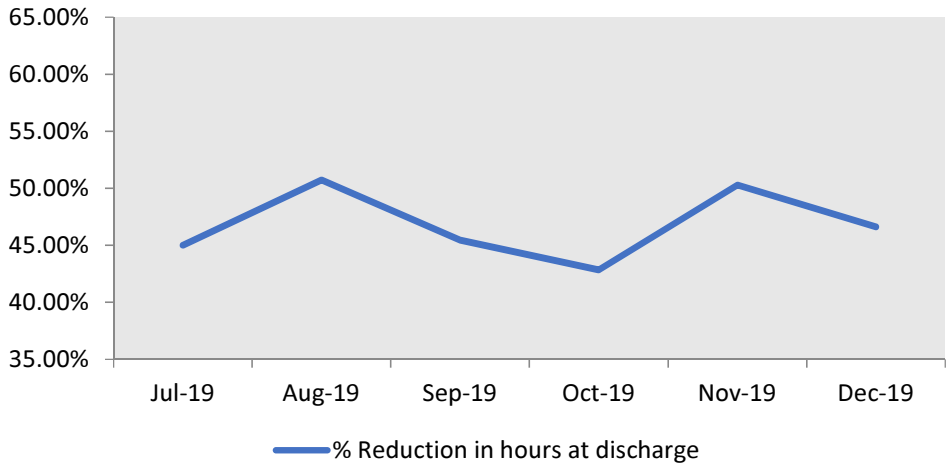
13. **% Completed Reablement Episodes discharged with no ongoing care**



14. **% Completed Reablement Episodes discharged with reduced care needs(incl no ongoing care)**



15. **D2A Project (HART) - % Net reduction in hours at discharge (Discharges in month)**



December activity is down due to normal seasonal factors, primarily patients temporarily cancelling visits as family step in to provide very short term support over Christmas.

It continues to be challenging to pick up large numbers of new patients due to the increasing congestion at the back door i.e. moving those contingency patients on to long term care providers

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Annex 3

Oxford University Hospitals NHS Trust

NHS Oxford Health NHS Foundation Trust

HART-CCS Joint assurance plan to Oxfordshire System Chief Operating Officers - December 2019

1	Prioritisation protocol
2	Performance dashboard
3	Performance improvement
4	Leadership and workforce development
5	Maximising system reablement opportunities
6	Performance and improvement trajectories

Oxford University Hospitals NHS Trust

NHS Oxford Health NHS Foundation Trust

1 Joint prioritisation protocol

What needs to happen…

- Agree and submit proposed protocol – for organisation internal review
- Review & sign-off by system COOs
- Trial implementation
- Full deployment of protocol

Update

- The Prioritisation Protocol commenced on 22nd October 2019.
- The progress of the implementation of the prioritisation protocol has been run through PDSA cycles by the HART Team.
- The feedback captured from the Team Leads within the PDSA cycle is that the prioritisation protocol has proven to be successful in making conversations easier with other colleagues within the Trust about referrals and wait times and provided the support they require to have those conversations.
- The next review has been scheduled for mid-January to report on progress made.

Oxford University Hospitals NHS Trust

NHS Oxford Health NHS Foundation Trust

1 Joint prioritisation protocol - Scenario

Community Hospital QDS Vs Acute QDS

Status	Team	Referrals source	Post Code	Level of Support	Package	Double Handed	Hours of care (Daily)	Hours of Care (weekly)	Care Type	HDRS or CRS	Site of Referral	Ward	Referral/Discharge Notice Date	Triage Date	Days Waiting from	Mobility	SDEC weighting	SDEC LOS bonus	LOS score	LOS Total	LOS	Mobility Score	Prioritisation Score	LOW Range
Triaged	South	SPA	OX11	AM, Lunch	QDS	Yes	4	28	Complex	CRS	SPA		21/11/2019	22/11/2019	25	Immobile	3	0	4	4	4	3	21	Waiting 22-28 days
Triaged	South	ICB	RG4	AM, Lunch	QDS	Yes	4	28	Complex	HDRS	ICB Chilterns Court		18/11/2019	18/11/2019	28	Immobile	3	0	4	4	4	3	21	Waiting 22-28 days
Triaged	South	URTS	OX12	AM	OD	No	0.5	3.5	Simple	CRS	URTS		02/12/2019	06/12/2019	14	Mobile wi	5	3	3	4	1	1	20	Waiting 8-14 days
Triaged	South	URTS	OX11	AM, Lunch	TDS	No	1.5	10.5	High	CRS	URTS		13/12/2019	14/12/2019	3	Mobile wi	5	3	3	4	1	1	20	Waiting 0-7 days
Triaged	South	Acute Hos	OX12	AM, Lunch	QDS	Yes	4	28	Complex	HDRS	John Radc 5A		30/10/2019	30/10/2019	47	Mobile wi	3	0	4	4	4	2	18	Waiting 29 days +
Triaged	South	Communi	SN7	AM, PM	BD	Yes	3	21	Complex	HDRS	Didcot Community H		16/10/2019	16/10/2019	61	Mobile wi	3	0	4	4	4	2	18	Waiting 29 days +
Triaged	South	ICB	RG8	AM, PM	BD	Yes	3	21	Complex	HDRS	Watlington ICB		21/10/2019	23/10/2019	56	Mobile wi	3	0	4	4	4	2	18	Waiting 29 days +
Triaged	South	Communi	OX10	AM, Lunch	QDS	Yes	6	42	Complex	HDRS	Abingdon Communit		23/09/2019	23/09/2019	84	Mobile wi	3	0	4	4	4	2	18	Waiting 29 days +
Triaged	South	OUT of Co	SN6	AM, Lunch	QDS	Yes	4	28	Complex	HDRS	Great Western Hosp		22/11/2019	22/11/2019	24	Mobile wi	3	0	4	4	4	2	18	Waiting 22-28 days
Triaged	South	OUT of Co	RG9	AM, Lunch	QDS	Yes	4	28	Complex	HDRS	Royal Berkshire Hosp		28/11/2019	28/11/2019	18	Mobile wi	3	0	3	3	3	2	15	Waiting 15-21 days
Triaged	South	OT/GP	SN7	AM, PM	BD	No	1	7	Moderate	CRS	OT		07/11/2019	07/11/2019	39	Mobile wi	3	0	4	4	4	1	15	Waiting 29 days +
Triaged	South	Communi	OX10	AM, Lunch	QDS	Yes	4.5	31.5	Complex	HDRS	Wallingford Commu		28/11/2019	28/11/2019	18	Mobile wi	3	0	3	3	3	2	15	Waiting 15-21 days
Triaged	South	ICB	RG4	AM, Lunch	QDS	No	2	14	Complex	HDRS	ICB Chilterns Court		12/11/2019	12/11/2019	34	Mobile wi	3	0	4	4	4	1	15	Waiting 29 days +
Triaged	South	FIT	OX12	AM, PM	BD	No	1	7	Moderate	CRS	FIT		04/12/2019	05/12/2019	12	Independ	5	3	3	4	1	0	15	Waiting 8-14 days
Triaged	South	EAU	OX10	AM, Lunch	TDS	No	1.5	10.5	High	HDRS	John Radcliffe		09/12/2019	09/12/2019	7	Independ	5	3	3	4	1	0	15	Waiting 0-7 days
Triaged	South	SPA	SN7	AM, PM	BD	No	1	7	Moderate	CRS	SPA		24/09/2019	24/09/2019	83	Mobile wi	3	0	4	4	4	1	15	Waiting 29 days +
Triaged	South	URTS	OX10	AM, PM	BD	No	1	7	Moderate	CRS	URTS		16/12/2019	16/12/2019	0	Independ	5	3	3	3	0	0	15	Waiting 0-7 days
Triaged	South	OUT of Co	SN7	AM, Lunch	QDS	No	2	14	Complex	HDRS	Great Western Hosp		28/11/2019	28/11/2019	18	Mobile wi	3	0	3	3	3	1	12	Waiting 15-21 days
Triaged	South	HUB	OX12	AM, PM	BD	No	1	7	Moderate	HDRS	The Alban Adams Tra		29/10/2019	29/10/2019	48	Independ	3	0	4	4	4	0	12	Waiting 29 days +
Triaged	South	Self Refer	SN7	Lunch	OD	Yes	1	7	Moderate	CRS	Family Member		16/10/2019	17/10/2019	61	Independ	3	0	4	4	4	0	12	Waiting 29 days +
Triaged	South	Communi	RG9	AM, Lunch	QDS	No	1.75	12.25	Complex	HDRS	Didcot Community H		29/11/2019	29/11/2019	17	Mobile wi	3	0	3	3	3	1	12	Waiting 15-21 days
Triaged	South	ICB	OX12	AM, PM	BD	No	1	7	Moderate	HDRS	ISIS		05/11/2019	05/11/2019	41	Independ	3	0	4	4	4	0	12	Waiting 29 days +
Triaged	South	Communi	OX12	AM, Lunch	TDS	No	1.75	12.25	Complex	HDRS	Didcot Community H		29/11/2019	29/11/2019	17	Mobile wi	3	0	3	3	3	1	12	Waiting 15-21 days
Triaged	South	Acute Hos	OX11	AM, Lunch	QDS	Yes	4	28	Complex	HDRS	John Radc CMU C		04/12/2019	04/12/2019	12	Immobile	3	0	1	1	1	3	12	Waiting 8-14 days
Triaged	South	SPA	SN7	AM, PM	BD	No	1	7	Moderate	CRS	SPA		02/09/2019	02/09/2019	105	Independ	3	0	4	4	4	0	12	Waiting 29 days +
Triaged	South	ICB	RG9	AM, Lunch	QDS	No	2	14	Complex	HDRS	ICB Chilte CMU C		29/11/2019	29/11/2019	17	Mobile wi	3	0	3	3	3	1	12	Waiting 15-21 days
Triaged	South	Adult Soci	SN7	Lunch	OD	No	0.5	3.5	Simple	CRS	Adult Social Care		23/10/2019	23/10/2019	54	Independ	3	0	4	4	4	0	12	Waiting 29 days +
Triaged	South	Acute Hos	OX12	AM, PM	BD	No	1	7	Moderate	HDRS	John Radcliffe		27/11/2019	27/11/2019	19	Mobile wi	3	0	3	3	3	1	12	Waiting 15-21 days
Triaged	South	SPA	SN7	Lunch	OD	No	0.5	3.5	Simple	CRS	SPA		10/10/2019	11/10/2019	67	Independ	3	0	4	4	4	0	12	Waiting 29 days +
Triaged	South	ILT	OX12	Lunch	OD	No	0.5	3.5	Simple	CRS	ILT		31/10/2019	31/10/2019	46	Independ	3	0	4	4	4	0	12	Waiting 29 days +
Triaged	South	Acute Hos	OX10	AM, Lunch	TDS	Yes	3	21	Complex	HDRS	John Radc CMU C		09/12/2019	09/12/2019	7	Mobile wi	3	0	1	1	1	2	9	Waiting 0-7 days
Triaged	South	SPA	OX10	PM	OD	No	0.5	3.5	Simple	CRS	SPA		27/11/2019	27/11/2019	19	Independ	3	0	3	3	3	0	9	Waiting 15-21 days
Triaged	South	Communi	RG4	AM, Lunch	QDS	Yes	4.5	31.5	Complex	HDRS	Wallingford Commu		05/12/2019	05/12/2019	11	Mobile wi	3	0	1	1	1	2	9	Waiting 8-14 days

The above snapshot of the waiting list shows two referrals; Community Hospital QDS (in pink) and an Acute QDS (in blue). They have both been scored the same based on their referral in line with the prioritisation protocol.

1 Joint prioritisation protocol - Scenario continued

QDS Packages Pick Ups

18/11/2019-15/12/2019	HART pick ups
QDS SH	
Community Hospitals	5
F.I.T. Home First	1
Horton Hospital	2
HUB BED	1
Intermediate Care Beds	2
JR Hospital	4
OCC Social and Healthcare Team	1
Royal Berks or other hospital outside	2
Self-Referral/Non-Professional	1
QDS DH	
Community Hospitals	5
Horton Hospital	1
JR Hospital	1
Royal Berks or other hospital outside	1
Grand Total	**27**

The above table shows the number of QDS pick ups from 18th November to 15th December 2019. The data has been split into:

- Single handed
- Double handed
- Referrer

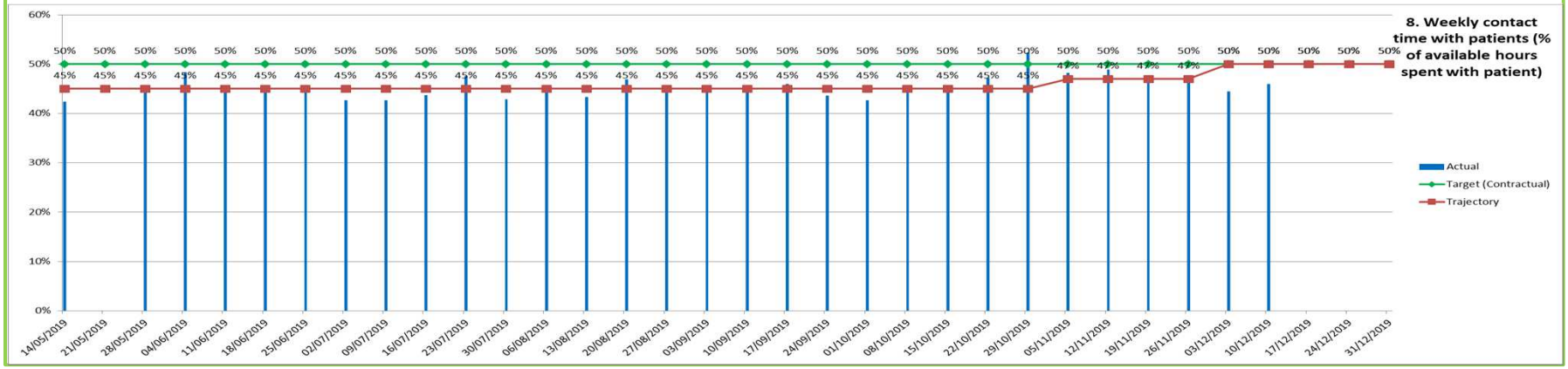
2 Performance dashboard

What needs to happen…

- Agree key performance indicators to be included in COOs dashboard
- Set up data feed and submission to COOs meeting
- Contact time (face to face) trajectory

Update

- The OUH & OH Combined Monthly Dashboard continues to be circulated on a Tuesday of the 2nd week each month.
- Each graph within the dashboard has been numbered for ease of reference.
- Commentary has been included within the dashboard for identified KPIs requiring more information on the progress of that month.
- Contact time (face to face) trajectory:



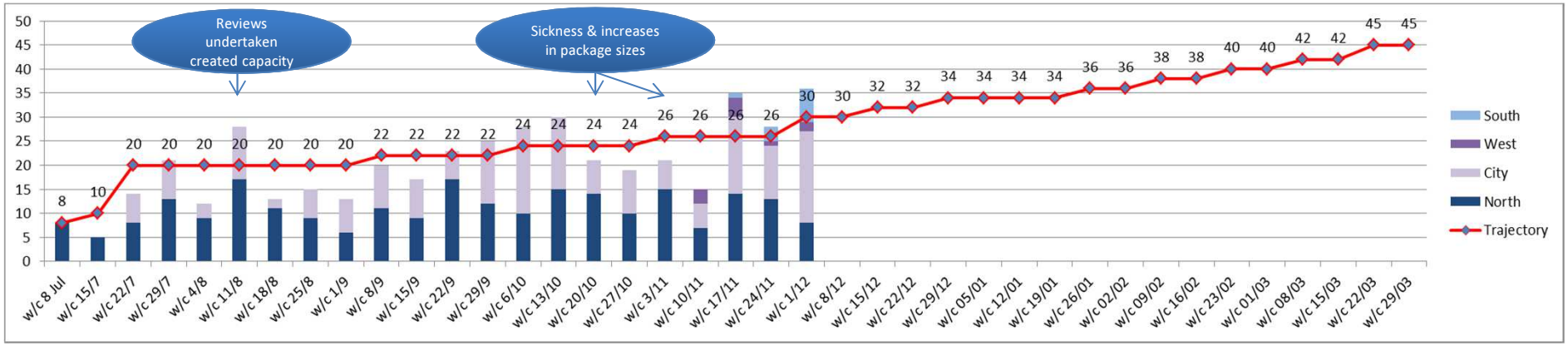
3 Performance improvement – reablement

What needs to happen…

- Therapy recruitment plan across both services
- Reablement training programme for all assessors and support workers
- Progressively scaled D2A county-wide service from all bed-based services

Update

- As of the end of December 2019 OUH have 5.04 WTE therapists supporting D2A.
- Reablement training programme for all assessors and support workers is online
- D2A has been rolled out successfully in the North and City with c. 450 patients in 22 weeks.
- D2A has now been rolled out within the West as of 11/11/19 and South as of 18/11/19 and are currently being run through improvement PDSA cycles.
- Multi disciplinary teams in North and City are continuing to review patients on the waiting list.
- There are currently 26 Assessors in post.



3 Performance improvement – reablement Continued

What needs to happen…

- Implement a new scheduling tool (CM2000 Max Care Scheduling Tool)

Update

Not currently being used due to issues reported previously

- Does not provide continuity of care as does not consistently put same RSW's with same SU's
- Does not keep consistency day to day so SU will have visits at different times from 1 day to next
- Does not use a master rota so difficult to visualise capacity on each day and fill any gaps or to predict what capacity is needed looking ahead.
- Time comparison not favourable to manual scheduling with no saving on mileage
- Training load for staff to use new system
- Time taken to input data vs manual drafting of rota's

4 Leadership and workforce development

What needs to happen…

- Joint recruitment strategy Implement comprehensive training programme, including leadership development
- Appoint to new head of service post and newly established service manager posts
- Deliver against submitted action plan in response to PAMMS rating

Update

- The Recruitment and retention strategy that has been produced will be reviewed by the new Head of Service and agreed with System Partner.
- A comprehensive training programme, including leadership development has been implemented.
- Following the radio adverts and assessment days, HART conditionally offered 8.84 WTE RSW posts. 2020 rolling Recruitment plan currently being devised.
- Interviews were held for Therapists in December and 2.80 WTE have been conditionally offered.
- HART will be recruiting an additional 2 WTE Assessors to align number of direct reports in North team.
- PAMMS update sent regularly. HART have received initial report and have sent Provider Comments in response.

Awaiting final rating, provisional rating GOOD

5 Maximising system reablement and rehabilitation opportunities

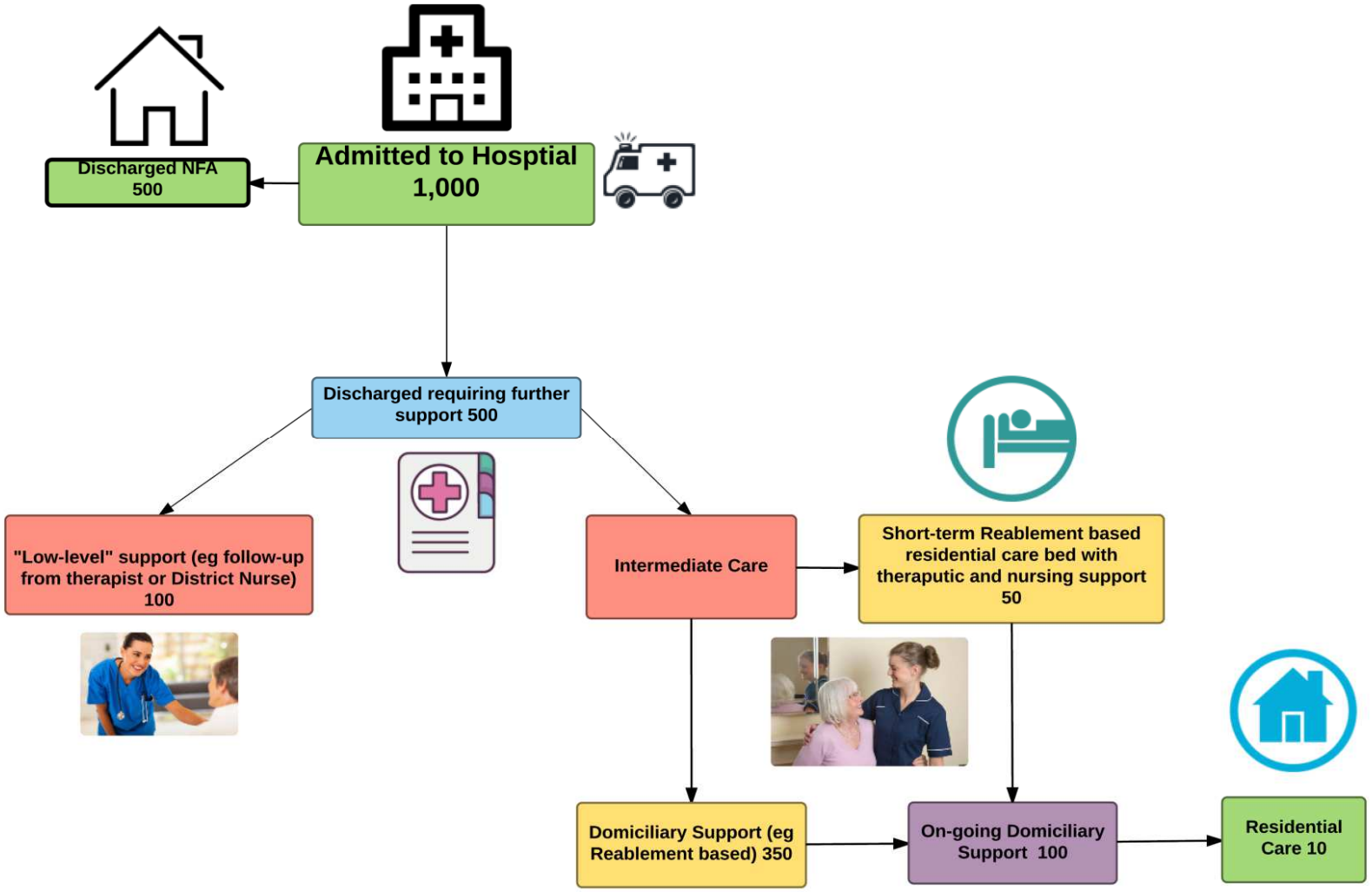
What needs to happen…

- Review the reablement opportunities within a service users' pathway. Incentivise these opportunities and instil performance accountability to minimise long 'super spell' length of stay.
- Explore alternative options to Home reablement for those leaving bedded rehabilitation or reablement services with prescriptions of double-handed QDS care.

Update

- HART are working closer with the ROT team exploring opportunities for them to become involved earlier in the pathway, pilot currently running in North
- Improved review compliance in HART see chart later in presentation
- Need for clarity about correct pathways for service users, see diagram below from John Bolton presentation. Are we maximising Reablement opportunities for the system by enabling some SU's to have both bed based and home based reablement ie giving some SU's in the county far greater than 6 week period identified by NICE guidelines for Reablement?

Flows through the system
Managing demand in adult care, London Feb 2017
John Bolton



Capacity within HART allocated to SU's referred from Community Hospital /HUB/ICB beds.

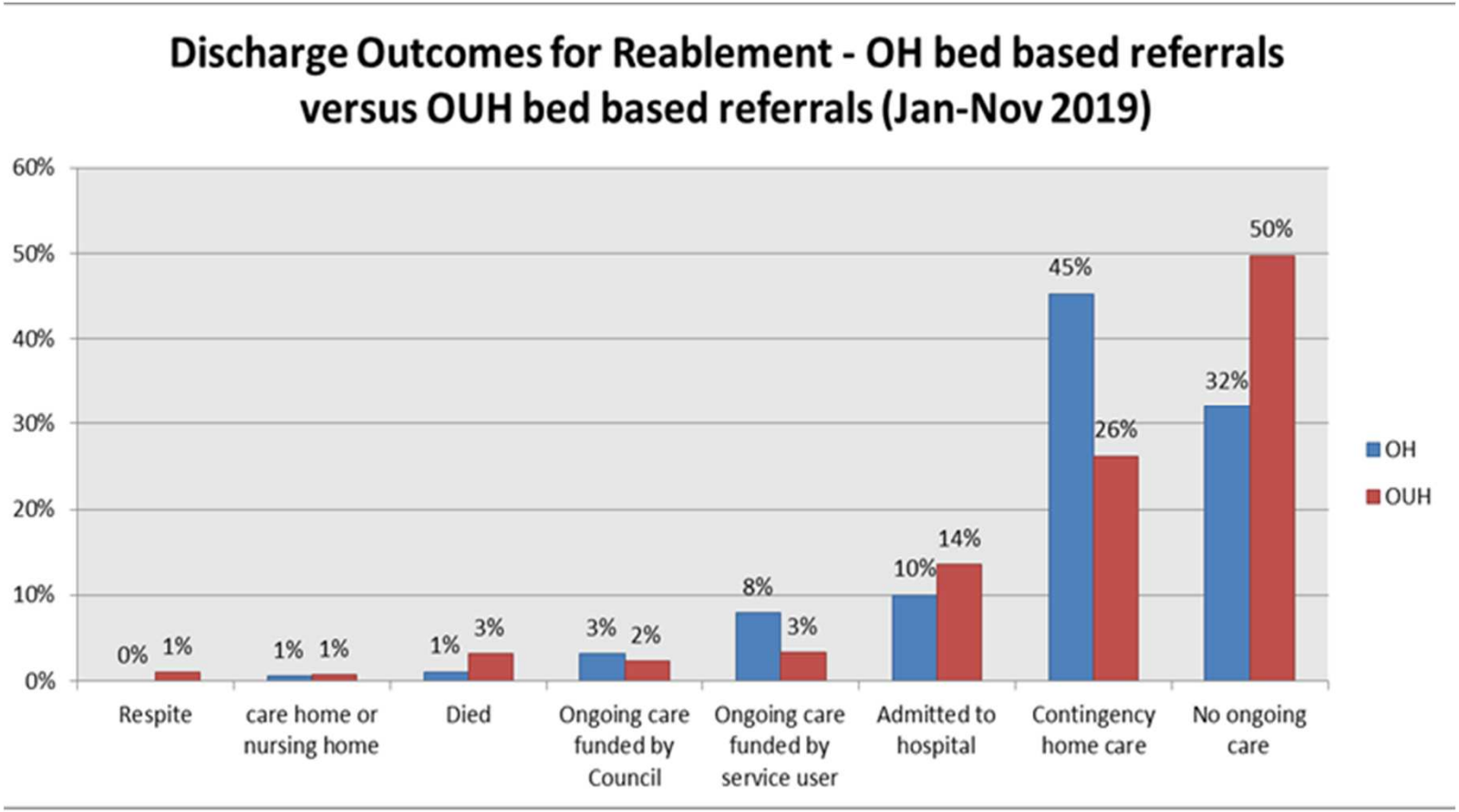
507 Patient episodes were discharged from HART between Jan 1st 2019 and Oct 31st 2019 that were referred from Community Hospital/HUB/ICB beds

This comprised of 366 reablement episodes and 141 contingency episodes.

The capacity used/allocated to these episodes could have supported 1374 contracted size (19.5 HRS) HDRS reablement episodes

Completed HDRS Reablement Episodes 01/01/2019-31/10/2019	Average LOW days	Average LOS days	% Completed Episode Reabled	# Patient episodes
Non OUH BED	28.1	29.8	47%	332
OUH BED	7.9	27.8	64%	493

Comparison of outcomes from referral source

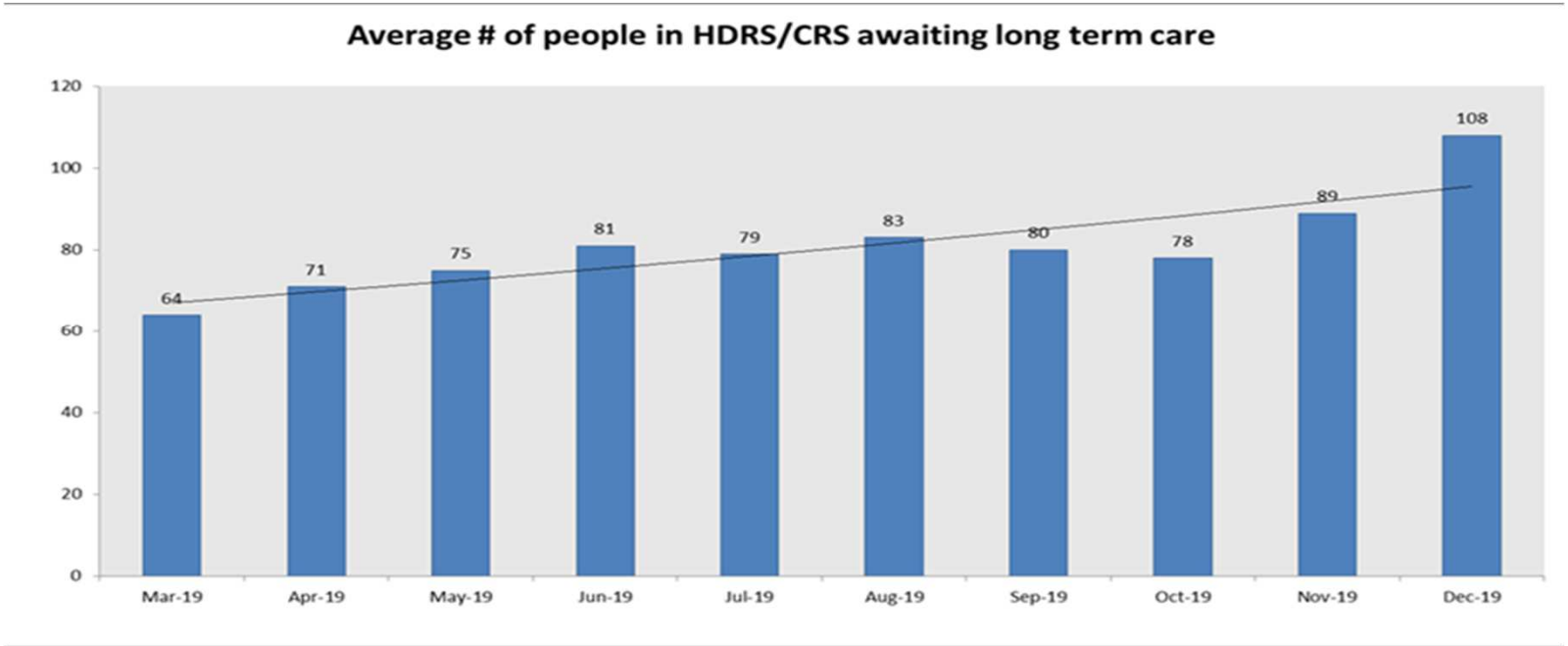


HART contingency patients

Update

- **In HART there are an average of 108 patients per day on the contingency contract requiring 1025 weekly hours of support.**
- **There were 35 patients at the end of November who have been waiting for over 50 days for long term care to be sourced by OCC.**
- **The weekly hours accrued by this cohort could have supported 311 CRS reablement episodes at current average package size.**
- **The longest of these waiters had been on the contingency contract for 443 days**

Increasing trend of contingency, is this sustainable for a Reablement service?



As of 3rd Jan 2020, **54%** of HART caseload are Contingency patients

Oxford University Hospitals NHS Trust

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6 Performance and improvement trajectories

Below are the revised improvement trajectories describing the baseline and forecast position in terms of current reablement staffing, activity through new episode acquisition. HART are currently budgeted for 150 WTE RSW, the future trajectory remains uncertain.

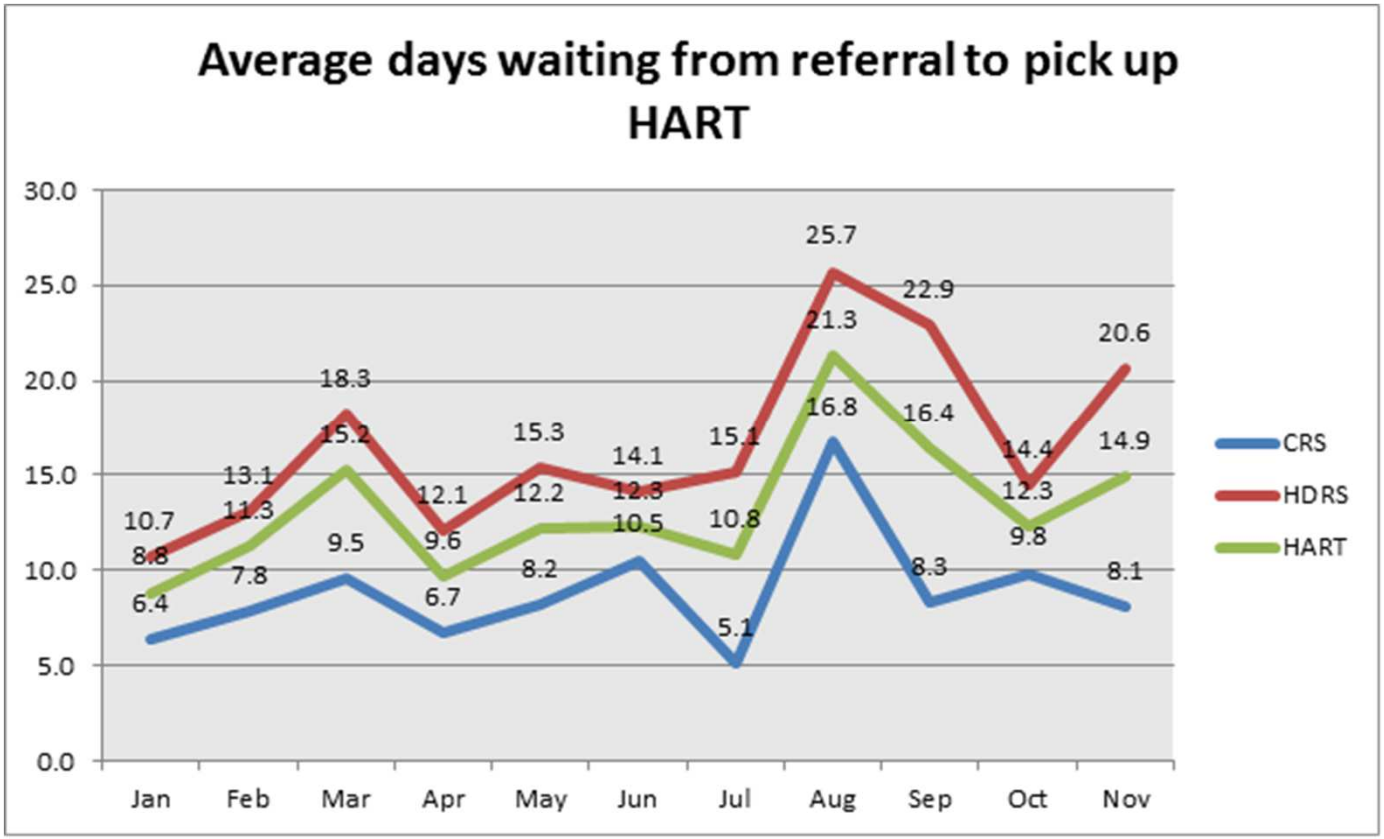
Year	2019							2020						
Month	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**
Reablement wte	-	-	-	-	135.0	135.0	135.0	137.0	140.0	145.0	150.0	150.0	150.0	150.0
Actual wte	137.09	136.53	134.85	134.12	134.01	132.80	133.09							
Episodes (new/month)	-	-	-	-	230	250	260	280	300	310	310	320	350	350
Actual episodes	177	242	198	225	233	202								

Update

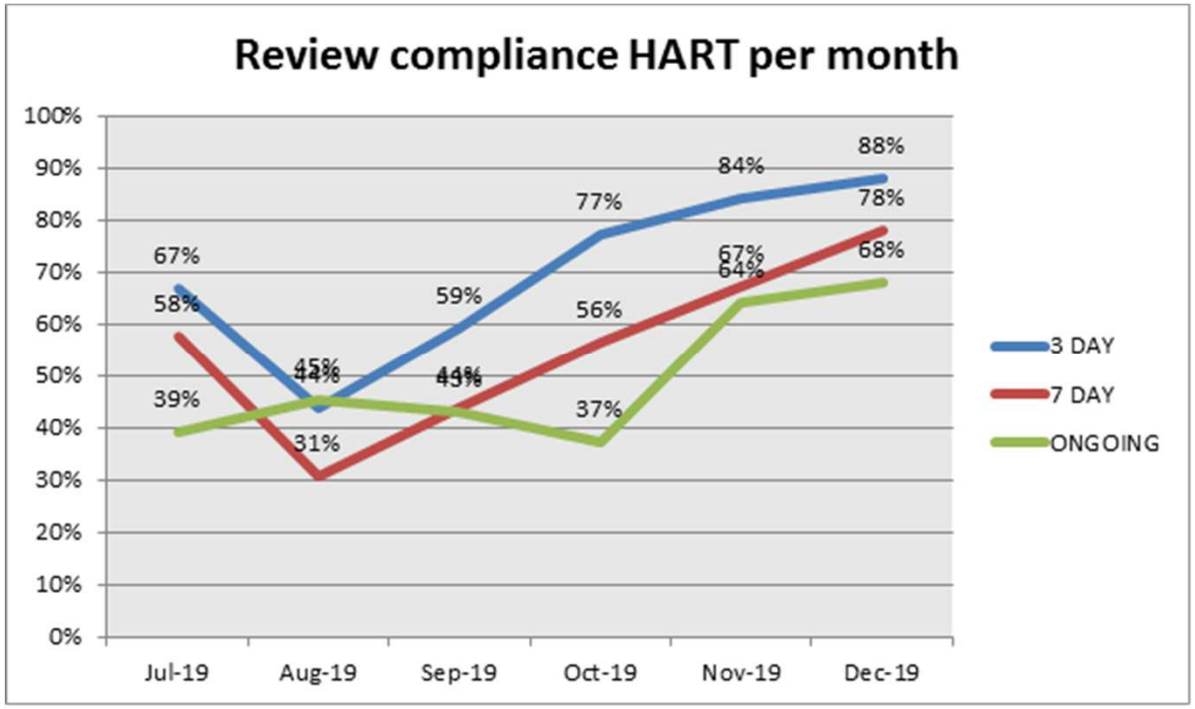
- Current position is 133.09 WTE for RSW.
- Start dates confirmed for 3.52 WTE RSW posts in December 2019.
- There is currently 2.12 WTE RSW posts planned to leave at the end of December 2019.
- Recruitment days have been undertaken regularly within the past few months with a total of 5.76 WTE RSW posts conditionally offered subject to pre appointment checks, there are a further 1.99 WTE due to start after January.

6 Performance and improvement trajectories continued

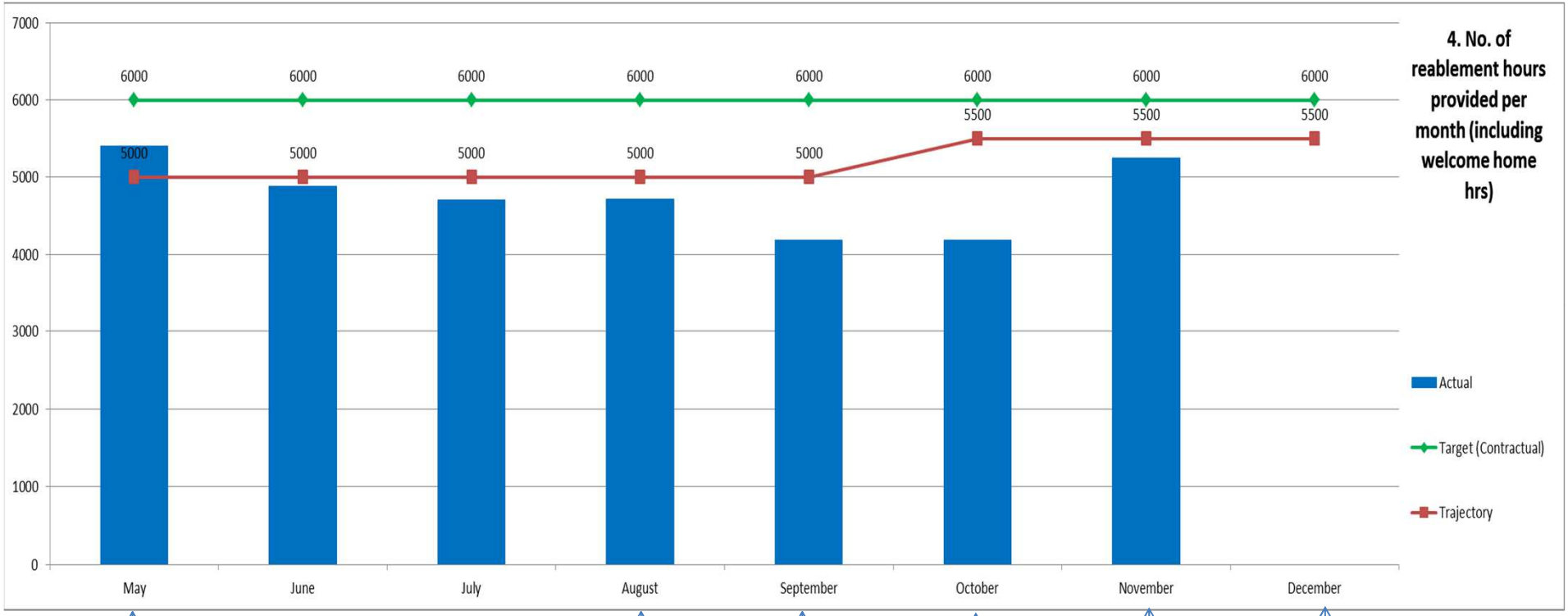
Below are the average days waiting for HART from referral to pick up for the reablement patients split by CRS and HDRS and for HART overall.



Review compliance



KPI 4: No. of re-ablement hours provided per Month (inc Welcome Home)



141 wte support workers in May

138 wte support workers in August

134.12 wte support workers in September

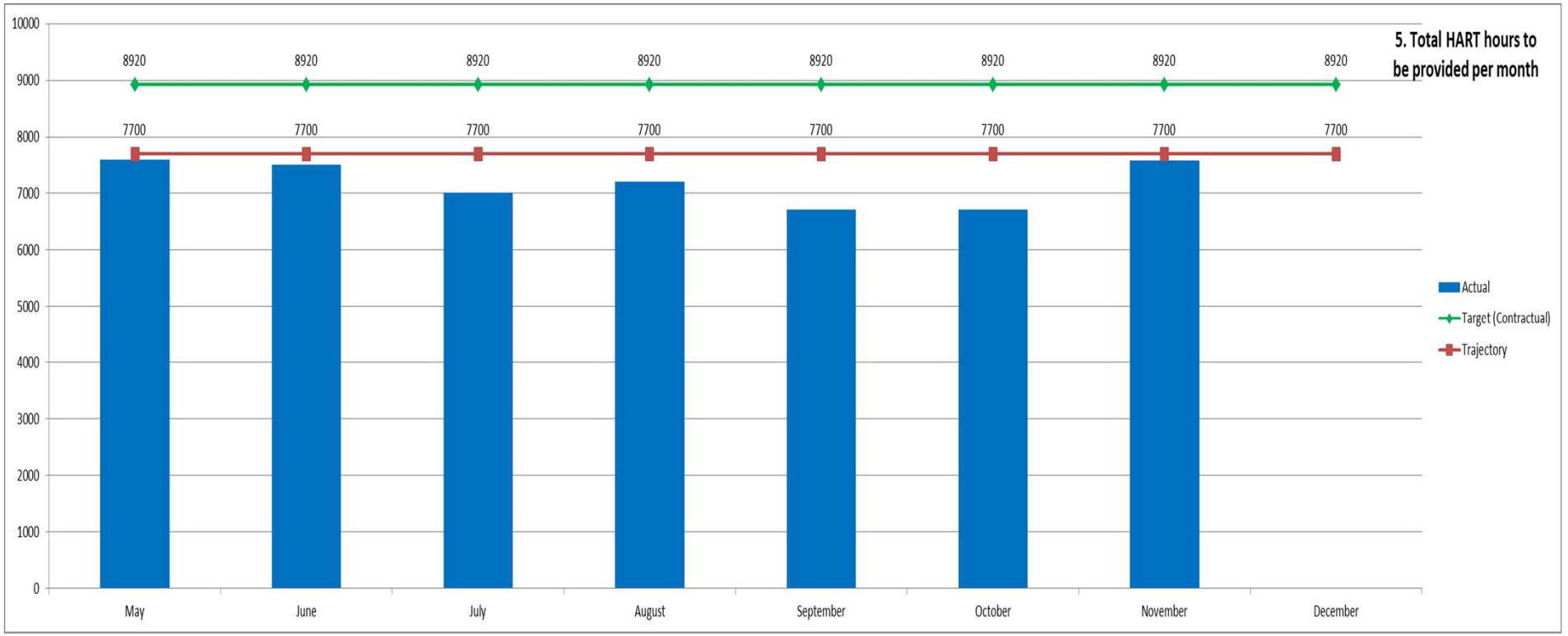
134.01 wte support workers in October

132.08 wte support workers in November

1.92 wte support workers to start in December

HART have released a Jack FM advert as a part of their recruitment drive, for Support Workers. This time of year will be particularly difficult as we will be competing with seasonal work offers

KPI 5: Total HART hours to be provided per month



141 wte support workers in May

138 wte support workers in August

134.12 wte support workers in September

134.01 wte support workers in October

132.08 wte support workers in November

1.92 wte support workers to start in December

This is impacted by contingency hours provided, although OUH and OH supplied 7578 hours in Novembercombined, and this is less than the agreed provision by 8920 hrs per month, release of contingency hours will further increase capacity back into the waiting list and improve flow of patients through HART.

Intermediate care definition

Explanation of intermediate care approved by Plain English Campaign (page 17 of your report)

3 main aims

1. Avoid going to hospital unnecessarily
2. Independence after a stay in hospital
3. Prevent move to residential care

Four service categories

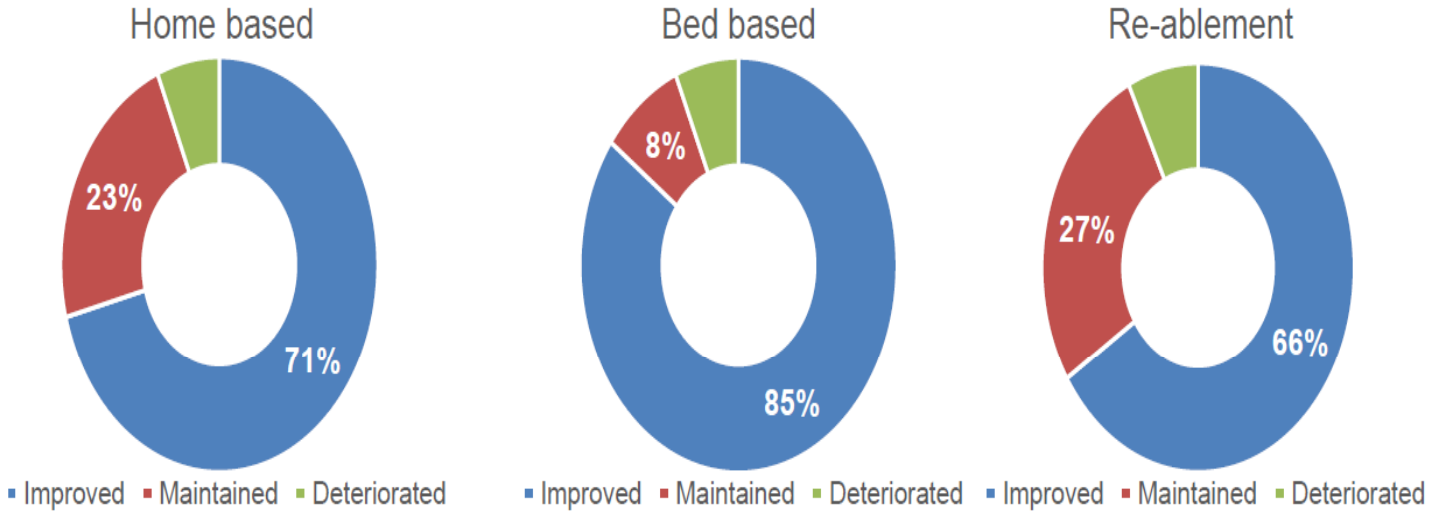
1. Crisis response
2. Home based IC services
3. Bed based IC services
4. Re-ablement

NICE used NAIC service category definitions

National Audit of Intermediate Care 2018

Does intermediate care work?

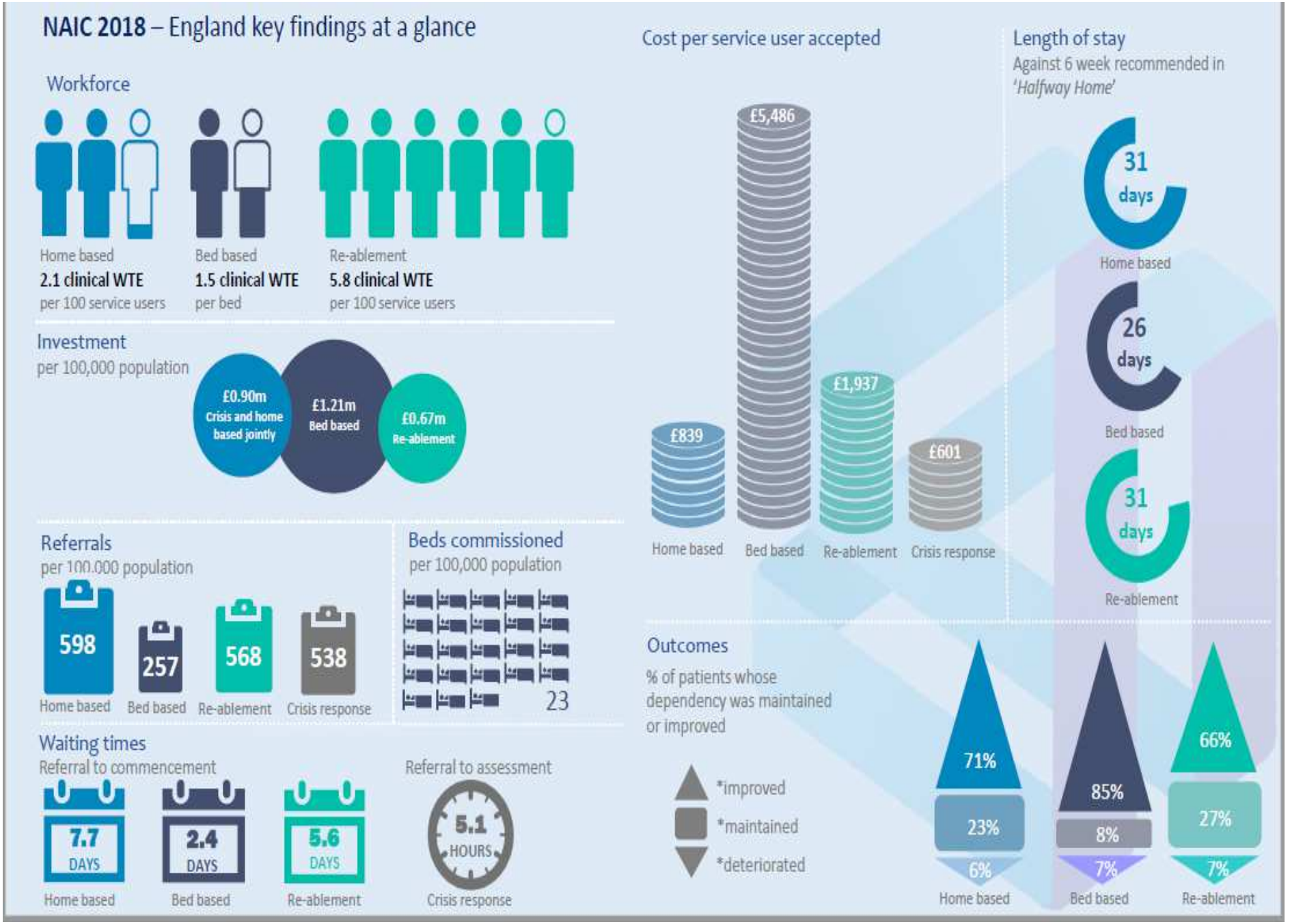
Service user outcomes: changes in dependency level



Vast majority have a positive outcome:

- Home: 94% improved or maintained (2017 93%)
- Bed: 93% improved or maintained (2017 93%)
- Re-ablement: 93% improved or maintained (2017 91%)

National Audit of Intermediate Care 2018


NAIC 2018 – England key findings at a glance
Workforce
Home based
2.1 clinical WTE
per 100 service users
Bed based
1.5 clinical WTE
per bed
Re-ablement
5.8 clinical WTE
per 100 service users
Investment
per 100,000 population
£0.90m
Crisis and home based jointly
£1.21m
Bed based
£0.67m
Re-ablement
Referrals
per 100,000 population
598
Home based
257
Bed based
568
Re-ablement
538
Crisis response
Beds commissioned
per 100,000 population
23
Waiting times
Referral to commencement
7.7
DAYS
Home based
2.4
DAYS
Bed based
5.6
DAYS
Re-ablement
Referral to assessment
5.1
HOURS
Crisis response
Cost per service user accepted
£839
Home based
£5,486
Bed based
£1,937
Re-ablement
£601
Crisis response
Length of stay
Against 6 week recommended in
'Halfway Home'
31
days
Home based
26
days
Bed based
31
days
Re-ablement
Outcomes
% of patients whose
dependency was maintained
or improved
*improved
*maintained
*deteriorated
71%
23%
6%
Home based
85%
8%
7%
Bed based
66%
27%
7%
Re-ablement

HART data to match NAIC data ie including maintained and improved outcomes

All Reablement HDRS	Improved or maintained	Improved	Maintained
Jan	90%	61%	29%
Feb	86%	54%	32%
Mar	89%	53%	36%
Apr	89%	57%	32%
May	94%	56%	38%
Jun	91%	51%	40%
Jul	93%	53%	40%
Aug	100%	50%	50%
Sep	99%	50%	49%
Oct	90%	46%	44%
Nov	88%	52%	35%
Average	92%	53%	39%

HART data to match NAIC data with completed episode cohort ie removal of RIP, Re-admissions, Private care

Completed Episode Cohort HDRS	Improved or maintained	Improved	Maintained
Jan	92%	72%	20%
Feb	93%	70%	23%
Mar	92%	63%	29%
Apr	92%	67%	25%
May	95%	68%	27%
Jun	92%	68%	25%
Jul	93%	63%	30%
Aug	100%	60%	40%
Sep	99%	58%	41%
Oct	94%	56%	38%
Nov	93%	60%	33%
Average	94%	64%	30%

Should HART KPI be adjusted to match NAIC data? ie maintained and improved outcomes not 75% to Independence, where has this figure come from?

NAIC 2019 - definitions

What is intermediate care?

Intermediate care services are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital. The services offer a link between hospitals and where people normally live, and between different areas of the health and social care system – community services, hospitals, GPs and social care.

What are the aims of intermediate care?

There are three main aims of intermediate care and they are to:-

- Help people avoid going into hospital unnecessarily;
- Help people be as independent as possible after a stay in hospital; and
- Prevent people from having to move into a residential home until they really need to.

Where is intermediate care delivered?

Intermediate care services can be provided to people in different places, for example, in a community hospital, residential home or in people's own homes.

How is intermediate care delivered?

A variety of different professionals can deliver this type of specialised care, from nurses and therapists to social workers. The person or team providing the care plan will depend on the individual's needs at that time.

IC function	Setting	Aim	Period	Workforce	Includes	Excludes
Crisis response	Community based services provided to service users in their own home/care home	Assessment and short term interventions to avoid hospital admission	Services with an expected, standard response time of less than four hours. Interventions for the majority of service users will typically be short (less than 48 hours) but may last up to a week (if longer interventions are provided the service should be included under home based IC)	MDT but predominantly health professionals	Intermediate care assessment teams, rapid response and crisis resolution	Mental health crisis resolution services, community matrons/active case management teams
Home based rehabilitation	Community based services provided to service users in their own home / care home	Intermediate care assessment and interventions supporting admission avoidance, faster recovery from illness, timely discharge from hospital and maximising independent living	Interventions for the majority of service users will last up to six weeks (though there will be individual exceptions)	MDT but predominantly health professionals and carers (in care homes)	Intermediate care rehabilitation	Single condition rehabilitation (e.g. stroke), early supported discharge, general district nursing services, mental health rehabilitation/ intermediate care
Bed based	Service is provided within an acute hospital, community hospital, residential care home, nursing home, standalone intermediate care facility, independent sector facility, Local Authority facility or other bed based setting	Prevention of unnecessary acute hospital admissions and premature admissions to long term care and/or to receive patients from acute hospital settings for rehabilitation and to support timely discharge from hospital	Interventions for the majority of service users will last up to six weeks (though there will be individual exceptions)	MDT but predominantly health professionals and carers (in care homes)	Intermediate care bed based services	Single condition rehabilitation (e.g. stroke) units, general community hospital beds not designated as intermediate care/rehabilitation, mental health rehabilitation beds
Re-ablement	Community based services provided to service users in their own home / care home	Helping people recover skills and confidence to live at home, maximising their level of independence so that their need for ongoing homecare support can be appropriately minimised	Interventions for the majority of service users will last up to six weeks (though there will be individual exceptions)	MDT but predominantly social care professionals	Home care re-ablement services	Social care services providing long term care packages

references

John Bolton research
https://www.local.gov.uk/sites/default/files/documents/John%20Bolton%20-%20Managing%20demand%20in%20adult%20care%20%281%29.pdf

NAIC audit 2018
http://www.careengland.org.uk/sites/careengland/files/NAIC%202018findings%20FINAL.pdf

NICE guidelines
http://pathways.nice.org.uk/pathways/intermediate-care-including-reablement

PERFORMANCE SCRUTINY COMMITTEE

PROPOSED WORK PROGRAMME

ITEM	NOTES
12 March 2020	
Business Monitoring Report	To consider the monthly business monitoring report.
Community Risk Management Plan (CRMP) 2020/21	To review the CRMP 2020/21
7 May 2020	
Business Monitoring Report	To consider the monthly business monitoring report.
9 July 2020	
Business Monitoring Report	To consider the monthly business monitoring report.
10 September 2020	
Business Monitoring Report	To consider the monthly business monitoring report.

TO BE SCHEDULED	
ITEM	**NOTES**
Homecare Budget	Requested at the 9th January 2020 meeting to receive a breakdown of the home care budget, by group, by setting and associated costs alongside a comparison with similar/neighbouring local authorities
Use of s.106 monies	Update on progress since the PSC deep dive into s.106/Community Infrastructure Levy (CIL) payments.
Investment Strategy	Scrutiny of the Council's Investment Strategy
Oxfordshire Local Transport and Connectivity Plan	Scrutiny of the Council's overall transport vision, goals and objectives to support population and economic growth.

Plans to tackle roadside NO2 concentrations	Council's approach to dealing with the impact of national policy to tackle roadside NO2 concentrations on Oxfordshire's transport network/ road infrastructure (i.e. ending the sale of diesel/petrol cars by 2040)
Strategic drivers	How the council is meeting its identified strategic risks, including council transformation and culture change, its relationship with external partners, building communities, etc.
Income generation	Scrutiny of the council's principles in relation to income generation, the opportunities available to the Authority and plans for increased income generation.
Turning Point Contract	To review and scrutinise the Turning Point Contract
Council workforce	How the Council is meeting its Investors in People standard, ensuring its workforce is diverse and representative of local communities, and building workforce resilience, including its relationship with Unison.
Key worker housing	A report on progress with addressing housing and affordability issues in Oxfordshire as one of the biggest barriers to attracting key workers for the care workforce.
Safeguarding Missing Children	An update on the number of children reported as missing from home, care and school in Oxfordshire and the work undertaken by the Missing Children's Panel and partners.
The Council's role as an Accountable Body	To gain a greater understanding of the Council's role as an accountable body particularly in relation to the Growth Board and Local Enterprise Partnership.