Item N°: 6

Health and Wellbeing Partnership Board
September 2010

Ageing Successfully

Executive Summary:

Purpose of Report

To report on work to progress 'Ageing Successfully +50 Onwards' and invite comments on specific partnership initiatives including the high impact priority areas.

History and context:

Why are we doing this?

Ageing Successfully is a local initiative that is designed to improve access to health and social care services by increasing the commissioning of integrated whole care pathways. This is being pursued to create a proportionate and appropriate shift from hospital into primary and community settings.

Where are we in the process?

Ageing Successfully was first brought to the Board in March 2009. Since then it has been developed with the Board's involvement and discussed at its last four meetings. It approved the strategy in March 2010. The HWBP Board will be asked to endorse the key delivery projects at its next meeting in December.

Where else has it been?

Ageing Successfully has links to a number of other priority programmes such as 'Creating A Healthy Oxfordshire', *Oxfordshire 2030*, Transforming Community Services, Transformation of Adult Social Care, Self Care and Urgent Care, Extra Care Housing, and Telehealth. It is therefore being discussed as appropriate in a number of other places.

Where else is it going?

There has been no determination (by the Chief Executives) from the review of existing governance arrangements for older people's services. In the meantime the HWBP Board will continue to exercise governance over Ageing Successfully, alongside other bodies and fora. Health Overview and Scrutiny will receive a progress report in December 2010. Involvement and consultation is taking place in a variety of ways with a diverse range of stakeholders.
Equality Impact Assessment are being completed for any proposed service developments.

Actions requested:
The Board is asked to: The Board is invited to comment on specific projects and initiatives in the Work Programme.

What does this item require members to take back to their organisation:
Members are asked to: Ageing Successfully is about working in partnership to improve health outcomes; promote independence, and reduce health inequalities for an ageing population. All agencies are faced with responding to demographic changes that will see a greater proportion of older people. Members are asked to encourage their own organisations to identify ways in which their activities and objectives support the framework set out in Ageing Successfully, specifically the six high level outcomes of: (i) staying healthy; (ii) staying independent; (iii) staying safe; (iv) lifelong learning; (v) being an active and involved citizen; and (vi) enjoying economic well-being.

HWB Partnership Board aims supported by this paper:	
☐	agree priority outcomes for health and well-being in Oxfordshire
☑	promote action across partner agencies in planning and commissioning services for health and social care improvement
☑	monitor delivery of action across partner agencies, assess effectiveness
☐	monitor health improvement and other outcomes across the county
☑	review priorities as part of the commissioning cycle
☐	support involvement of service users in developing a strong strategic role
☑	further the development of joint financial arrangements
☐	ensure the implementation of priorities set out in the Sustainable Community Strategy and delivery of Local Area Agreement targets

Author of paper:	**Person on whose behalf this has been written:**
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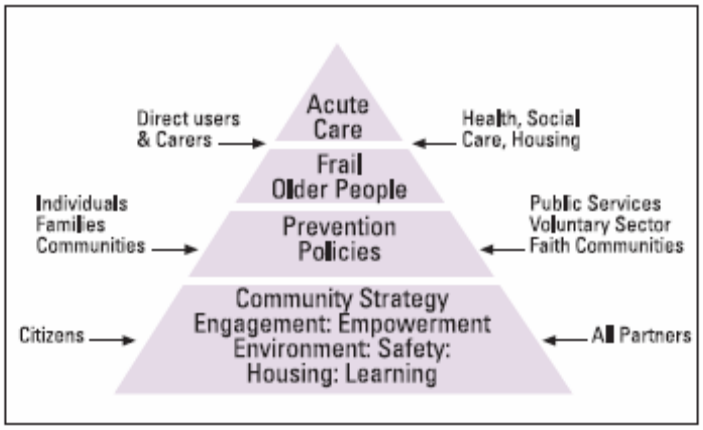
Last date paper modified: 03 September 2010

Ageing Successfully +50 Onwards: September Progress Report

1. Background

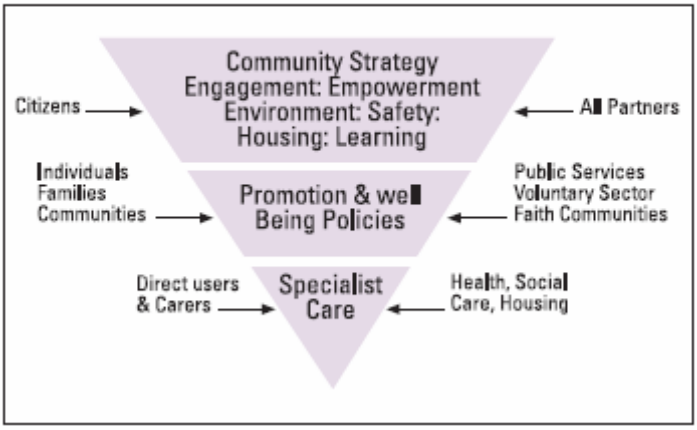
1.1 The Health & Well Being Partnership Board approved the Ageing Successfully strategic framework on the 18th March 2010 and received a progress report in June 2010. The Ageing Successfully strategic approach is to place much greater emphasis and investment on promoting and maintaining well being and consequently deferring and preventing the need for more expensive, acute and intensive interventions. 'All our Tomorrows: Inverting the Triangle of Care'[1] states most resources for older people are focused on those with the most severe needs. Central to Ageing Successfully is inverting the 'triangle of care'. In figure 1 the statutory services are concentrated at the tip of the triangle.

Support for Older People Today *Figure 1*



The objective is to reverse the trend by inverting the triangle so that the community strategy and promotion of well being is at the top of the triangle and the extension of universal services for **all** older people is seen as crucial to **all** agencies, see Figure 2.

Support for Older People Tomorrow *Figure 2*



[1] 'All our Tomorrows: Inverting the Triangle of Care' LGA and ADASS 2004

1.2 An essential ingredient of Ageing Successfully is the engagement of a range of partners across Oxfordshire in a whole system approach with a focus on a substantial number of initiatives, programmes and projects. These are outlines in Annex B and include the high impact priorities: promoting healthy lifestyles (primary prevention), pathway redesign (falls, dementia, stroke and continence), Rehabilitation, Reablement, Day Services/ Opportunities; Carers, and implementation of the Dementia Strategy. There are a number of significant programmes of work that are all aimed at preventing a person from becoming ill or frail; helping some-one to manage a condition as well as possible or prevent a deterioration in an existing condition(s). In practice some interventions defy easy categorisation and may combine different types of prevention at the same time.

Primary Prevention	Targeted Prevention	Tertiary Prevention
• Exercise programme • Good Neighbors Scheme • Age Proofing • Mobile Information Unit • Adaptations/practical support	• Rehabilitation • Reablement • Telecare • Pathway Redesign • Turnaround • Falls Prevention • Carers Support • Extra Care Housing • Dementia initiatives	• Personal Health Budgets • Personal Social Care Budgets

2. Involvement Strategy

2.1 To deliver the scale of change envisaged is involving a wide and diverse range of stakeholders: individuals in receipt of services, carers, clinicians, GP's, district councils, staff, providers, the voluntary sector and wider communities of interest across Oxfordshire to ensure that contributions inform the work in progress. Good engagement is reflecting in individuals and agencies being involved in the relevant projects. A meeting with the LSP coordinators raised opportunities for further engagement with local communities.

3. Conclusion

3.1 Ageing Successfully has benefits for an ageing population through a whole system approach to interventions and service delivery, in which partners, older people and carers work together more effectively to improve access, remove duplication and share resources. The Ageing Successfully approach facilitates the development of key approaches, interventions or services to maintain independence and improve the well being of older people in a cost effective manner. This is based on a growing recognition that only a more preventative agenda will be sufficient to respond to current and future pressures.

Marie Seaton,
Interim Head of Joint Commissioning (Older People)
02 September 2010

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Annexes

Day Opportunities: Outline of Proposals

1. Purpose:

The purpose of this paper is to provide the members of the Health and Well Being Partnership Board an outline of the proposals for future day opportunities for older people.

2. Introduction and definition:

We all need activity and interaction to live meaningful lives. For many people, this means occupational activity, making social contact and developing interests in the community and at home. Those eligible for social care services want to participate in their local communities in similar vein; some people need more specialist facilities and support to enable them to do so.

The proposal outlined in the paper is considering a move away from day care/ services to day opportunities.

By 'day opportunities' we mean the things people want to do during the day. This covers all opportunities for older people whether it be the day, evening or at the weekend. This is different to 'day services', which refers to those services commissioned by Social & Community Services such as traditional, building based centres. The change in terminology reflects a shift from building based 9 to 5 'day care' which once entered became a lifelong service to a concept of offering a range of support and services on different days of the week in different venues that maximise independence and offer activities tailored to meet individuals' needs.

The approach for day opportunities is reinforced by the development of 'Ageing Successfully'[2] that sets out a strategic framework to support an ageing population in Oxfordshire and reflects the key policy drivers:

- Personalised services will promote independence, choice and control through the use of personal budgets to meet individual needs;
- A focus on health and well being, prevention, early intervention and community building to support people closer to home and avoid unnecessary admissions to hospital or residential care;
- More focussed support for those with long term conditions such as stroke or dementia;
- Support will be relevant to marginalised and excluded groups, such as those from black and ethnic communities;
- Access to universal services information and advice is a priority.

Personal budgets for older people who are eligible to receive them will shift the purchasing decisions and power from commissioners to individuals to make their individual choices. Currently many of the day services are funded through block contracts but going forward we propose to part fund only and this means providers will need to market their services to meet the choice of individuals and entice people to spend their personal budget with them by offering what people want.

[2] 'Ageing Successfully – Forward from 50' March 2010.

3. Current position in Oxfordshire:

Oxfordshire County Council spends in the region of £4.8 million to deliver and purchase a wide range of day support across the County.

A much wider range of occupational or activity opportunities are provided by voluntary agencies, community groups and special interest groups.

Oxfordshire County Council spends above the average of comparator authorities on day services – more than twice as high as the average. This reflects the fact that we support twice as many places as others. An analysis of current day services usage and referral routes for existing services suggests that approximately one-third of the attendees are FACS (Fair Access to Care Service) eligible, and therefore in future will receive a personal budget to purchase their services.

However it is fair to say that despite an above average spend there are areas of the county that are not well served.

4. Vision for day opportunities for Oxfordshire:

Oxfordshire County Council promotes a vision that supports flexible, personalised support to older people that enables them to take advantage of opportunities to:

- Enjoy social and leisure activities of their choice;
- Have access to community and social networks that maintain their independence; Take part in meaningful community, occupational and leisure activities;
- Participate in mainstream activities to meet aspirations to live as normal a life as possible without stigma.

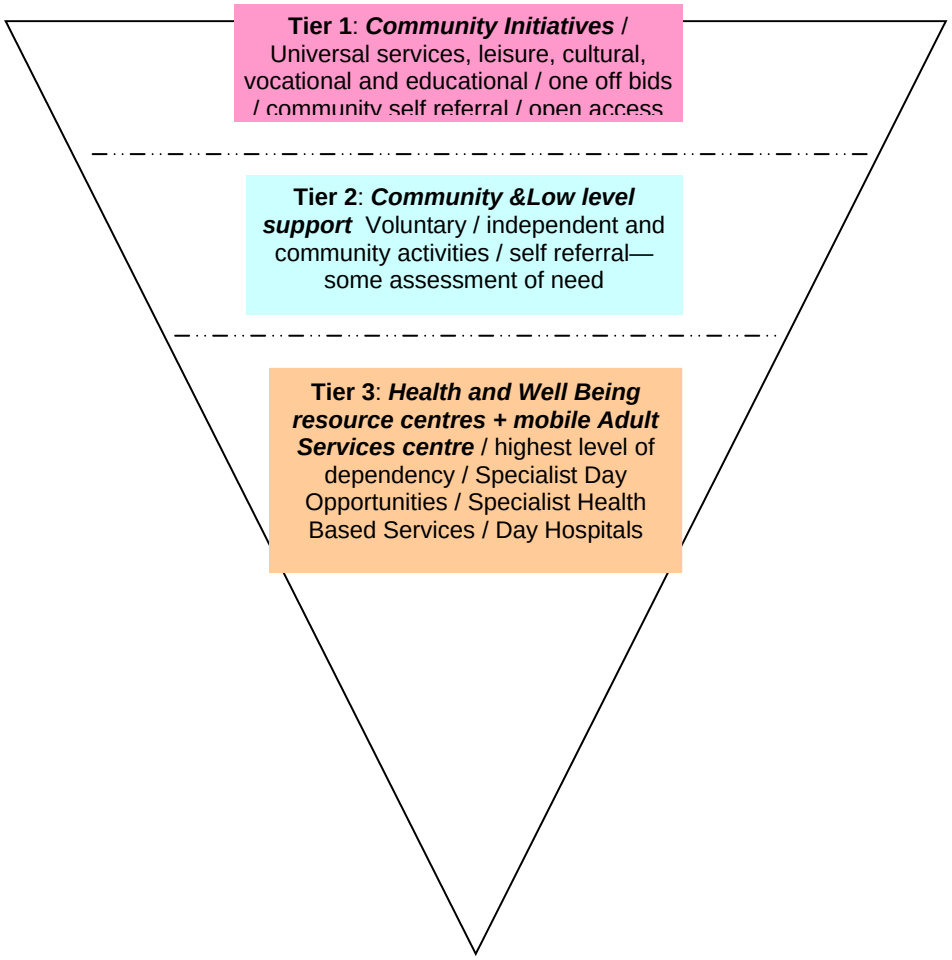
5. Proposed day opportunities model

The national and local developments outlined above should ensure older people become better integrated within their communities. Reducing social isolation and the maintenance of independence is primary.

To deliver these objectives a strategic framework is required to underpin effective development of a flexible range of options and choices that can meet individual needs, not only of current users but those likely to need services in the future.

'Ageing Successfully' and the development of day opportunities place much greater emphasis and investment on promoting and maintaining well being and consequently deferring and preventing the need for more expensive, acute and intensive interventions. The proposed model inverts the Triangle of Care (see p.3, Fig. 2) and universal services become predominant and the need for older people to have information about what is available locally to meet their particular needs becomes paramount. The proposed model of day opportunities indicates three tiers reflecting the range of universal services, specific support, and specialist social and health care provided to individuals and their carers.

Figure 3: Triangle of Care Three Tier Model



Tier 3 Health and wellbeing (building based) + Mobile unit

This tier will deliver services to those with the highest level of dependency and will it will be a mixture of building based a centres and mobile centre that will reach out older people in rural parts of Oxfordshire.

It is proposed that the future resource centres will be renamed and referred to as **Health and Well Being Resource Centre**. The key features of the provision in these centres will be to:

- Promote the health and wellbeing of older people and support their emotional and psychological well being;
- Provide early short term rehabilitation where there is the potential to increase or regain independence;
- Improve or rebuild confidence following a bout of illness so that people can live independently at home;
- Provide information and advice to reduce risk of falling, improved health and respiratory care, diabetes care, etc;
- Provide access to a range of universal health support (dentistry, podiatry, eye check etc);

- Improve awareness of the importance of healthy eating and nutrition
- Use self-assessment tools for simple services, like smaller aids and equipment and appropriate occupational therapy support and provision of mobility and equipment for daily living;
- Provide respite opportunities to support break for carers (7 days per week basis);
- Access to Occupational Therapy assessments and Community Psychiatric Nurses support for people with dementia;
- Provide a range of social, leisure, learning and exercise (7 days per week basis including evening opportunities);
- Respond to the use of personal budgets and develop imaginative, individualised support package which use mainstream services to meet needs;
- Targeted support for small groups of people who have similar needs or interest.

Mobile Adult Services Centre (MASC)

Building based services have their limitations as they tend to be more costly because of the necessary overheads, such as rent, building maintenance, heating and lighting costs and in the case of Adult Social Care's day services for older people, the need to pay for transport to bring service users to the centres. There may also be accessibility issues for people with a physical disability when a service is provided in an older rented building.

The purpose of the MASC would be to provide to vulnerable, isolated older people in both rural and urban areas a range of information, advice and access to services, including:

- Health information, advice and services, including access to assessment and low level equipment
- Other information and/or advice
- Improved outcomes as people are better informed to make choices
- An opportunity for isolated older people to meet with others in their community

A detailed model is being development and will form part of the transformation of day services 2011/12.

Tier 2 Community and Low Level Support

It is envisaged that the type and range of support for Tier 2 will be locally determined and people who use these services will tend not be eligible for social care support. Tier 2 services are likely to be used by carers who are seeking respite from caring those people who are frail or vulnerable but do not have high levels of need. It is suggested the 14 locality 'Closer to Communities' boundary areas are the focus for Tier 2. Local decision making will decide how the resources should be used in a locality taking account of local needs and the availability of universal services and community activities which do not require funding. The support therefore should have the potential to be delivered in a range of venues (including support in peoples own homes). It is envisaged that the needs will be locally identified and communities will be instrumental in determining the best possible means of responding to meet these.

Tier 2 funded services for older people will need to ensure that they:

- Work with an outcome-based focus for each individual;
- Wherever appropriate act as enablers for individuals to access Tier 1 services;
- Contribute to the broader prevention agenda through the provision of health promotion activities e.g. the provision of a nutritious meal; prevention of hypothermia;
- Facilitate access to relevant sources of financial, health, social care etc;
- Address the needs of socially excluded groups, such as those from black and ethnic minority communities.

Local governance structures will be developed to ensure that the needs of local communities are fully considered.

A level of central support will be provided to ensure consistency of approach.

Tier 1 Community Engagement

The sense of health and well being engendered by becoming or remaining a valued member of the community is well recognised by all those supporting older people. Individuals should be enabled to access and become active contributors to the range of universal social, leisure, clubs, voluntary and learning activities based in the community. Many older people may no longer need costly specialist provision if mainstream services were better prepared to accommodate their needs. 'Ageing Successfully' includes an initiative to ensure the 'Ageing Proofing of services and professional practice meet this requirement. Making mainstream services more accessible will have high impact benefits for significant numbers of people.

To ensure older people enjoy a good quality of life a need has been identified to enhance community based options over and above the ones outlined above. Two options are proposed: the development of an adult mobile centre and one off bids for small amounts (no more than £750) of funding to support older people in their communities.

Harnessing the support of volunteers to deliver a range of practical support will also be a key aspect of this tier of support. For example extend the development of good neighbour scheme across the county.

6. Next steps:

A presentation that outlined ideas and a direction of travel has been delivered to a wide range of stakeholders. Feedback was invited and has influenced the development of the proposals outlined in this paper.

There is further work in progress, with the aim of a detailed proposal to be in place and presented to the Adult Social Care Scrutiny and the Cabinet. It is anticipated that a general an agreement for a way forward will be in place by the end of October 2010.

A period of consultation with various stakeholders will be undertaken, and followed by development of a detailed implementation plan.

Rehabilitation: Summary of Progress

Purpose

The work aims to develop skilled, responsive, flexible and cost effective rehabilitation delivery across the whole system.

Expected outcomes

- Improved productivity
- Improved whole life outcomes for individuals
- Reduced LOS in bed based care
- Improved use of bed based care
- Improved through put
- reduced disability levels for individuals

Key milestones

- July 2009 – business case for re-alignment of the Assessment and Enablement service agreed at Joint management group
- September 2009– new service specification for community rehabilitation as contract variation with Community Health Oxfordshire
- September 2009 - Model for rehabilitation to Joint Management Group and Creating A Healthy Oxfordshire board

Outcomes already realised

- Improved rehabilitation pathway in Stroke care
- Improved rehabilitation pathway in Hip fractures
- Early supportive discharge teams in Hip fracture and stroke

Stroke Rehabilitation: Summary of Progress

Purpose

This project is to deliver high quality rehabilitation for all adult stroke survivors, ensuring this is delivered in the right place at the right time, in line with the National Stroke Strategy and development of care in Oxfordshire.

Expected outcomes

1. Develop standards for stroke rehabilitation
2. Develop information pathway
3. Agree and implement model of leadership for stroke rehabilitation
4. Agree model for psychological support
5. Develop Community Forum for Stroke including newsletter and interactive website**.**

Key milestones

Some deadlines of project slipped due to Care Quality Commission Stroke Review in June and July which had priority. Leadership role and neurological outpatient work had to be put on hold due to review of Assessment and Enablement Service.

- Feb 2010 Stroke Forum established
- April 2010 Newsletter and Interactive website completed.
- June 2010: Information Pathway work completed.
- July 2010: Draft Psychological Support Proposal presented to Stroke Development and Implementation Group.
- October 2010: Final Psychological Support Proposal to be presented to Stroke Development and Implementation Group for endorsement.
- October 2010 Rehabilitation Standards to be implemented

Outcomes already realised

- Standards developed and agreed.
- Information pathway developed
- Proposal for psychological support completed
- Community Forum, newsletter, interactive website in place.

Fragility fractures and Falls Prevention: Summary of Progress

Purpose

To develop an integrated pathway for Fragility Fractures, with business cases for the component parts;

To continue to develop the work of Falls prevention.

Expected outcomes

- Reduce the number of fragility fractures
- Reduce the length of stay in bed based care following a fracture
- Improving the quality of care following a fracture
- Reduce the number of avoidable falls in the elderly

Key milestones

1. Accelerated fractured neck of femur pathway in place
2. Improved rehabilitation for hip fractures
3. Business case for fracture prevention service to clinical executive October 14th
4. Business case for making non-conveyed fallers pilot into a county service to Delayed Transfer Of Care Board September
5. Integrated fragility fracture pathway in place

Outcomes already realised

Pilot of non-conveyed falls between SCAS and fall's prevention team – start April 1

- Reduction in repeat fallers in the pilot area
- Reduction of admissions to hospital
- Improved care within an individuals home

Pilot of accelerated pathway for fractured neck of femur started July 19th

- Improved quality of care pre and post operative
- Reduced LOS in acute care
- Improved standards of rehabilitation
- Reduced cost to public services by improved outcomes

Dementia and Older People's Mental Health: Summary of Progress

Purpose

The work is driving forward implementation and development of Dementia services and improvements in line with the National Dementia Strategy. The work is focused on 5 workstreams:

1. Improved quality of living
2. Early diagnosis and complex care
3. Early onset dementia
4. Information provision
5. Making change happen / cross cutting issues

This is a programme of work based on partnerships between the statutory and voluntary sectors, with service users, carers, clinicians and general practitioners across Oxfordshire.

Expected Outcomes

1. Improved quality of living:
   - Development of structured peer support networks
   - Improved community personal support services
   - Implementing the carers strategy
   - Housing support and telecare
   - Living well with dementia in care homes

2. Early diagnosis and complex care:
   - Improved End of Life Care for people with dementia (Led by PCT EOLC Team)
   - Good quality early diagnosis and intervention for dementia
   - Improved care for people with dementia in general hospitals
   - Improved intermediate care for dementia

3. Early onset dementia:
   - Needs assessment for younger people
   - Action plan to address the needs of younger people

4. Information provision:
   - Good quality information for people with dementia and carers
   - Enabling easy access to services
   - Awareness raising

5. Making change happen / cross cutting issues:
   - Workforce development for dementia
   - Dementia commissioning strategy
   - Service mapping, including finance

Key Milestones

1. Improved quality of living:
   - Mapping peer support
   - Proposed peer support model for Oxfordshire
   - Community support service procured
   - Service for carers training and support established
   - Pilot of assistive technology
   - Service pathway and good practice guide developed for care homes

2. Early diagnosis and complex care:
   - Increased use of EOLC register for dementia
   - Redesigned memory assessment service, including clear pathway
   - Pathway, guidance and workforce plan for general hospitals
   - Business case for improved intermediate care

3. Early onset dementia:
   - Needs assessment and business case for early onset dementia service
   - Scoping of needs for people with a learning disability and dementia

4. Information provision:
   - Dementia information line established
   - DementiaWeb updated
   - Dementia Advisor demonstrator site work evaluated

5. Making change happen / cross cutting issues:
   - Joint commissioning strategy for dementia produced
   - Workforce strategy for dementia

Outcomes already realised

- Community support service operational
- Carers training and support established
- Dementiaweb updated

Progress update for August

1. Improved quality of living:
   - Peer support option paper produced
   - Care home admissions pathway and first draft “best practice” booklet produced

2. Early diagnosis and complex care:
   - Memory Assessment service specification produced, aim for contract variation to be signed end September

3. Early onset dementia:
   - Needs assessment completed, business case in development

4. Information provision:
   - Evaluation of Dementia Advisor service underway
   - Information line launched, service building up towards full operational level.

5. Making change happen / cross cutting issues:
   - Draft commissioning strategy for approval at October Dementia Development and Implementation Board
   - Dementia service and finance mapping almost completed.

Older Peoples Mental Health Strategy

Purpose

To create an older peoples mental health strategy for Oxfordshire

Expected Outcomes

Older peoples mental health strategy created and agreed

Key Milestones

Draft strategy created by September
Consultation September – November
Final strategy agreed by December

Outcomes already realised

Draft strategy created; consultation to begin Mon 06 September 2010

Personal Health Budgets: Summary of progress

Purpose

Use personal health budgets as a means of promoting and extending public and patient involvement and choice in the NHS care they receive. This means giving people real choice over their treatment; real control over how the money is spent; and real power to hold local services to account.

Expected outcomes

- Fit for purpose operational delivery system to enable the full use of personal health budgets in continuing care in Oxfordshire.
- To have a lean integrated administrative system across both health and social care – well trained workforce to deliver personal health budgets.
- To have shifted the perspective of both clinical and public communities to the concept of personal health budgets.
- To have an integrated resource allocation system to work with individuals for both individual health and social care budgets; to deliver a single individual budget where appropriate.
- To have a measurable increase of both individual ability to self determine care and support delivery.
- To demonstrate that personal health budgets are a cost effective way of delivering services for the whole health and social care community.

Key milestones

- Develop initial PHB operational policies and procedures that work.
- Establish brokerage service to work with continuing care clients in developing individual packages of care.
- Develop robust third party and direct payment delivery models.
- Establish and deliver communication strategy, including public consultation.
- Ensure a robust governance framework is in place.
- Workforce training is available around personalisation agenda.
- Develop models to determine cost effectiveness of personal health budgets.
- Map personal health budget delivery systems to other service delivery areas.

Outcomes already realised

- Initial operational policies and procedures developed – first personal health budgets and support plans are working.
- Brokerage service (joint development with Social Care) working effectively.
- Communication plans in place – patient reference group working well, patient consultation pages available on ‘Talking Health’, GP and pharmacy briefings planned.
- Initial governance framework in place.
- Workforce training plan in place within continuing care.
- Beginning mapping process - initial meetings with other service delivery areas taking place.

Age Proofing: Summary of progress

Purpose

A request was made for some thinking to be done around Age Proofing, in order to:

- find out what partners were doing locally (there was a feeling that this was an issue many organisations were keen to address);
- find out what was being done elsewhere in the country and to identify any good practice Oxfordshire could learn from; and
- suggest some ways forward to remove barriers preventing people living full and active lives (since improving uptake of mainstream services improves wellbeing and can help to reduce or delay the need for costly specialist services).

Initial findings

WODC and PCT were both interested in ensuring their continued compliance with forthcoming legislative duties in relation to age equality and in improving the appeal of their services to those residents entering into 'later life' but didn't have anything currently in place to achieve this.

Approaches elsewhere in the UK seemed to consist of work along two broad lines:

(i) a toolkit/ checklist/ self assessment style material

(ii) various mechanisms to increase involvement of older people in decision making

PLUS some specific changes that could be replicated (e.g. use of smart cards to promote multiple benefits to older citizens)

Outcomes already realised

So far we have:

- completed a literature review;
- created a locally applicable toolkit (in DRAFT);
- established a two-pronged consultation/ engagement process;
  (i) phase 1, half way through – finding out what local older people think
  (ii) phase 2, faltering a little – trying to establish a panel of willing road-testers

[a separate strand to involve the private sector was dropped when LAA Reward funding was cut – £1,000 is required to resurrect]

- begun a report presenting the 'business case'/ rationale and suggesting possible actions to replicate good practice elsewhere (very DRAFT);
- compiled a positive images bank.

Changes to the governance arrangements

Work was briefly suspended as a result of changes in the political and economic landscape, nationally and locally. The Project Sponsor (on behalf of the County Council Management Team (CCMT)) retired and upon departure advised that CCMT would not wish to launch an ambitious Age Proofing strategy at the present time. The reasons for this are varied but include the fact that their focus is currently on managing financial pressures and that 'Ageing Successfully' has emerged to address the void originally identified by the Comprehensive Performance Assessment (CPA) (which, along with its successor (CAA), was shelved by the new government).

These events meant there was a need to reassess the Project Plan and to identify a new set of governance arrangements. It was agreed that oversight of the project would be passed to Ageing Successfully. This was advantageous as it helps clarify potential overlap and synergy with the Prevention Strategy. And it would enable the project to be correctly positioned in relation to Age Concern's recent output 'Growing Older in Oxfordshire – A Tale of Two Counties'.

Next steps

As a result of reviewing the governance arrangements, it has been agreed that the Age Proofing project be re-conceived as an initial feasibility study, with a report to be presented to the Ageing Successfully Commissioning Group early in 2011, in time for a recommendation to be brought to the March meeting of the HWBP Board. The aim of the feasibility study will be to produce a report highlighting the differences that initial pilots have already made and thus demonstrating the benefits to be achieved from using an age proofing approach. This will then enable the Board to identify what mechanism(s) should be used to implement anything the project might seek to address.

The following nine service areas or strategic plans have been proposed as suitable candidates for piloting the locally developed toolkit:

1. Diabetic retinopathy service
2. Waste & recycling collection service
3. Another service from West Oxfordshire District Council
4. Witney Pharmacist
5. Benson GP Surgery
6. Get Oxfordshire Active
7. Physical Activity Action Plan
8. Transforming Adult Social Care Board Information Plan

These offer a good range of different types of service, in different organisations and across different geographical locations. They also represent a good mix between functions and policies. Trialling the toolkit in this way will enable the collection of evidence that can be used to establish if efforts to age proof local services and plans can be successful without additional funding being available.

It is suggested that if the toolkit proves helpful it be taken forward and incorporated into organisations' work around Equality Impact Assessments and thus become an extension of existing arrangements to address potential discrimination.

The consultation work with a number of older people's groups will be written up into a short report, so that a local perspective can be offered in addition to that gathered from a review of national research. This will be used to help identify which services in particular older people feel need age proofing first.

Service Area / Development	***Re-ablement***

Brief Description of Change and Impact of Change

Develop the Council's existing re-ablement service into a service that performs in line with national benchmarks.

Re-ablement is a service for people with poor physical or mental health to help them accommodate their illness or a long term condition by learning or re-learning the skills necessary for daily living. It is distinct from rehabilitation which helps people to get better and recover from their illness or condition. Common principles and features of a re-ablement service include:

- Helping people 'to do' rather than 'doing to or for' people
- Outcome-focused with defined maximum duration – typically up to 6 weeks
- Aids accurate assessment for ongoing care packages by observation over a defined period rather than a one-off assessment

The objectives of re-ablement are to:

A. Maximise service users' long-term independence, choice and quality of life
B. Minimise appropriately the ongoing support required, and thereby,
C. Minimise the whole life-cost of care

Re-ablement is currently provided by the Assessment & Enablement Service. Work is underway to establish the in-take and performance baseline for the service – essential for establishing the future cost and savings that the service can be expected to achieve. There is a growing body of evidence that re-ablement will deliver significant benefits and savings. A retrospective longitudinal study[3] for Department of Health (CSED)[4] showed that:

- 53% to 68% of service users left re-ablement requiring no immediate homecare package
- 36% to 48% continued to require no homecare package two years after they had received re-ablement

Of those that required a homecare package within the two years after re-ablement:

- 34% to 54% had maintained or reduced their homecare package two years after re-ablement

Although we are not yet able to confirm the level of savings that could be achieved from the development of re-ablement, CSED have estimated that Oxfordshire could potentially save millions of pounds on the cost of ongoing homecare as a result of re-ablement. The actual savings yield will be dependent on confirmation of the current service in-take and performance baseline, establishment of the state of the current service and scale of change required to optimize performance, and confirmation of the forecast in-take to the service.

[3] *Retrospective Longitudinal Study of the Effects of Homecare Re-ablement*, 2009, Social Policy Research Unit, University of York. Further information is provided at: http://www.dhcarenetworks.org.uk/csed/homeCareReablement/prospectiveLongStudy/

[4] CSED = Care Services Efficiency Delivery team

Improving outcomes for older people and their carers

The vision is to develop a re-ablement service that will help many older people to recover their independence and take control of their lives. The service will help older people, and also people with mental health problems, to re-learn daily living skills, such as managing their own medication or washing and dressing and so will also ease the burden on carers. As well as reducing demand for ongoing social care services, re-ablement will enable older people in particular to resume or improve their ability to get out of doors and walk down the road; wash face and hands; have a bath, shower or wash all over; get dressed and undressed; having control of the bladder[5]. There is evidence also that re-ablement improves perceived quality of life among service users and perceived health.[6]

Impact on performance (levels of complaint, legislative challenge, adverse media etc)

- **Positive** – evidence suggests that re-ablement can enable people to manage independently and that this benefit is sustained for 2 years or more in a high proportion of cases.

Impact on Staff

- **Positive** – re-ablement really is a 'job worth doing' and should help to counter problems with recruitment and retention of care staff. Demand for homecare rose by 80% 1994-2004 and is projected to continue to rise. At the same time, the proportion of people within age bands that historically deliver homecare services will reduce so recruitment to match demand is likely to be impossible.

Impact on Reputation

- **Positive** – with careful management and leadership focused on optimizing performance, Oxfordshire will be able to demonstrate real and significant benefits in terms of improved outcomes for large numbers of vulnerable older people and their carers, and cashable savings.

Timetable for Change

- Completion and approval of business case for service development, including forecast cost and savings and recommended approach to procurement, by October 2010
- Interim service specification developed by end October 2010
- Final service specification confirmed and new service arrangements commence January 2011

Risk Analysis

- Establishing the baseline and current state – current business processes and recording arrangements make this difficult.

[5] CSED Prospective Longitudinal Study on Re-ablement – Interim Report, October 2009, Social Policy Research Unit, University of York and PSSRU, University of Kent

[6] Ibid – post re-ablement phase, service users were reporting fewer problems with mobility, self-care, usual activities, pain/discomfort, anxiety/depression and improvements in their general health

Service Area /Development	***Turnaround***

Brief Description of Change and Impact of Change

Implement the "Turnaround" targeted approach to service user risk identification, management and recovery

Turnaround is a new concept and approach to promoting independence and prevention. It aims to identify people who may be on a pathway towards high dependency and residential care, and turn them back. The concept has emerged from work led by Adult Social Care and involving the Institute of Public Care (IPC) which identified a potential target group of people who may be on a pathway towards long term residential and nursing care, who could potentially be 'turned back' - if they are identified soon enough and offered support that is 'right' for them. This work also applies to those at risk of hospital admission. IPC identified a number of gaps and weaknesses in the current menu of services, such as a focus on outputs rather than outcomes and disconnected service provision across the public and voluntary sectors.

The Turnaround Project has set out to develop the Turnaround concept and approach, and to answer 3 key questions:

- Can we identify people who are at risk of entering residential / nursing care?
- Can we identify evidence-based approaches to service interventions that cut across existing boundaries and are effective in turning people back?
- Are individuals willing to engage with turnaround and able to be restored to independence?

The project has focused on answering these key questions and developing the concept, through a series of work-packages including:

- Finding potential service users – development of a predictive model and screening tools
- Evidence-based approaches – establishing the evidence about what works, mapping available services that can be called upon to deliver a timely response to recipients of the Turnaround approach, and identify gaps
- Consultation with older people – this has served to underline the importance of social isolation, loneliness and bereavement and is shaping how we develop the approach

We have also been refining our thinking about what Turnaround actually is and where it fits within the social and health care system. We've concluded that Turnaround's key characteristics are applicable and beneficial not just in isolation but to the organization as a whole:

- ✓ Identify people at risk
- ✓ Target people at risk with a personalized response or service
- ✓ Provide evidence-based, outcome-focused support across disciplines
- ✓ Focus on restoration and recovery

But will it work in practice? We are planning to roll-out Turnaround from Autumn 2010, as:

1. A set of values that we want all our staff to work with, for the benefit of all service users
2. A specialist, funded approach for a small group of people who are identified as being "at risk" but who also have the potential for recovery

Savings of £140,000 pa ongoing from 2011/12 are already set against this initiative. Our modeling of the potential savings that could be achieved if the Turnaround approach proves to be successful is much greater. For example, assuming that:

- We can successfully identify 70%[7] of people at risk of entering a residential care home within the next 12 months and we target these people with a personalized, evidenced based service intervention, and
- We are successful in 10% of cases
- We could save £261,331 by delaying these people's entry to residential care by 3 months, based on current prices for residential and nursing care.

We still need to establish the likely cost of the Turnaround intervention which would need to be off-set against this saving, and there will be limited other ongoing costs. However, if over time we are able to target people earlier e.g. 2 or 3 years away from potential entry to long term residential care, then the savings yield is likely to be greater because we would also save money on homecare etc. Work is ongoing to test the model further before it can be used.

Improving outcomes for older people and their carers

We know that older people want to maintain their independence and do not wish to end their days in residential care. Many accede to this outcome because they do not wish to be a burden on their families. The Turnaround approach will help ASC to deliver a more personalized service response to all service users, and right sort of extra help for those at with the best potential for recovery. In doing so, we should help more people to retain their independence and relieve pressure on other social care services, still needed by many other older people but who have less potential for recovery and restoration.

Impact on performance (levels of complaint, legislative challenge, adverse media etc)

- **Positive** – Turnaround will fill a gap in Adult Social Care's current service response which currently frustrates both professionals, service users and carers who can often see the potential for independence to be regained, but cannot get the help that they need to do so, when they need it.

Impact on Staff

- **Positive** – Consultations so far have shown staff to be enthusiastic about the concept and keen to be involved. Potential barriers to their sustained engagement are however a lack of capacity within the system to deliver essential services in a timely manner, e.g. Physiotherapy.

Impact on Reputation

- **Positive** – The County Council has already been praised by DH (John Bolton) for its innovative work on Turnaround.

Timetable for Change

- Confirmation of approach to trial, by September 2010
- Approach development and specification, September 2010
- Go Live in one locality, October/November 2010

[7] This is subject to the next stage of testing our predictive model, but the Stage 4 version suggests that this is possible. Source: *Turnaround: Predictive Modelling* Report, *August 2010* - Chris Morris, Oxfordshire PCT

- Full Go Live, December 2010
- Business case including evaluation and recommendations for future development, March 2011

Risk Analysis

- Scale and pace of roll out – risks are currently being assessed and will be used to inform decisions
- Ensuring that Turnaround can access required skills and services in a timely manner, within an already stretched system
- Managing and protecting the Turnaround concept – being clear about what it is, what it isn't and what we want people to do differently as a result
- Staff resource – a range of skills are needed to implement effectively, but these are in demand from a number of other areas

Service Area / Development	***Continence***

Brief Description of Change and Impact of Change

Continue to work in partnership with the PCT and health care providers to:

1. **Transform the Bladder & Bowel (Continence) Service and**
2. **Improve awareness and understanding among Social Care Staff of what can be done to promote continence among the 62,000 people in Oxfordshire thought to be affected by some form of incontinence[8]**

Social & Community Services has been working together with Oxfordshire PCT to assess the current performance of the Bladder & Bowel (Continence) Service in the county and develop a blueprint for change. The impetus for this joint project came from research led by Adult Social Care and involving the Institute of Public Care which showed that 44% of people that we currently fund into long term residential care have urinary incontinence as an issue at admission.

Incontinence has been described as a social problem with a health solution. For this reason the majority investment in Bladder & Bowel services will continue to come from health[9], with the greatest savings being realized by avoiding inappropriate referrals into secondary and acute services. Social care also stands to benefit if more older people can be helped to receive the correct treatment and recover from incontinence – this is both a realistic and an evidence-based outcome (see below). Current data recording practices in both social and health care make evidencing these savings difficult[10], however capturing and collating basic data about the people who ASC fund into residential care and their presenting needs and conditions should help us to see the impact and benefits of the transformation of continence services in the county.

Incontinence affects a wide range of people at different life stages. 1 in 4 women and 1 in 10 men will experience a loss of bladder or bowel control at some point during their life, prevalence of loss of bladder and bowel control rising with age. However, incontinence is a treatable condition. Research has shown that key types of incontinence[11] treated with simple pelvic floor and bladder training resulted in a reduction weekly episodic incontinence of between 68 and 94% of both men and women. Treatments are low tech, simple and low cost.

A business case to transform the Bladder & Bowel Service in the county was accepted by the PCT's Clinical Executive Board in July 2010. Work to transform the service has already begun and includes:

- Patient pathway re-design
- Development of a home delivery service for continence products, to release district nursing time
- **Developing the skills and knowledge of social care staff around incontinence and what they can do to maintain individual's continence health**

[8] *Business Case for the Re-design of (Continence) Bowel and Bladder Services in Oxfordshire, V2* – Suzanne Jones and Rachel Lawrence, July 2010

[9] Current total spend on continence services is estimated to be around £4M pa

[10] Incontinence is rarely recorded on patient and service user records, either because it is treated as 'secondary' to another condition, for example, a stroke, or because the GP, health practitioner or social worker has failed to ask whether this is a problem

[11] Ibid. Types = stress, urgency and mixed bladder incontinence

The focus on raising awareness of incontinence and promoting treatment is supported by evidence which links the condition to a range of other conditions and events with high cost implications. For example:

- **Falls and fractures** - there is a significant association between incontinence and an increased risk of falls and fractures in the elderly. The risk of falling is increased by 45% for those with any symptoms of incontinence. The average cost to the NHS of treatment for a hip fracture is approximately £28,000.
- **Urinary Tract Infections (UTIs)** - incontinence is a major risk factor for recurrent urinary tract infections which frequently require hospital admission. Elderly women with UTIs are three times more likely than those without to have vertebral fractures.[12]
- **Pressure ulcers** – people who are incontinent are more likely than others to develop hospital acquired pressure ulcers[13]. The cost of care per ulcer was estimated in 2004 to be £1,064 for a grade one ulcer and £10,551 for a grade four.[14]
- **Leading factor in care-home admission** - A study from Bournemouth reported that incontinence is one of the strongest predictors of care home admission, together with confusion, unstable gait, recurrent falls in hospital, impaired vision and use of tranquilisers. Incontinent patients were 2.5 times more likely to be discharged from hospital to a nursing home than other patients.[15] It is also worth noting that older people have frequently only acquired incontinence since being in hospital, where the focus may have been on another condition, such as a stroke
- **Dependence on a range of social and health care services** - incontinence in men leads to a greater reliance on a range of services. Incontinent men reported a greater use of all community services, with the greatest differences seen in home services such as day care, home nursing, meals on wheels, shopping, and special transport services.[16]
- **Reduced mobility** - incontinence is a significant barrier to regular exercise, which is crucial to maintaining mobility in later life. Women with severe incontinence are 2.64 times more likely to be insufficiently active than women with less severe or no symptoms of incontinence.[17]

S&CS are now working to raise awareness about incontinence and what can be done about it through changes to induction training for new social care staff and further work to challenge perceptions and beliefs among existing social care staff.

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[12] Eriksson I, Gustafson Y, Fagerstrom L, et al. (2010) Prevalence and factors associated with urinary tract infections (UTIs) in very old women. Archives of Gerontology and Geriatrics 50(2)**:** 132-135

[13] A study of pressure ulcers acquired in one US hospital by patients over the age of 65 reported that over a three year period, 16% of ulcers were acquired by patients with urinary incontinence, 25% by patients with fecal incontinence and 34% by patients with both types. By comparison, patients with no incontinence accounted for 4.5% of hospital acquired pressure ulcers - Baumgarten M, Margolis DJ, Localio AR, Kagan SH, Lowe RA, Kinosian B, Holmes JH, Abbuhl SB, Kavesh W, Ruffin A, (2005) Pressure Ulcers Among Elderly Patients in the Hospital Stay. The Journals of Gerontology; Series A; Biological sciences and medical sciences 61(7): 749 - 754

[14] Bennett G, Dealey C, Posnett J (2004) The cost of pressure ulcers in the UK. Age and Ageing 33 (3): 230-235

[15] Aditya BS, Sharma JC, Allen SC, et al. (2001) Predictors of nursing home placement from a non-acute geriatric hospital. Clinical Rehabilitation 17 (1):108-113

[16] McCallum J, Simons LA, Simons J, Dong T, Millar L, (2007). Risks and Burdens of Incontinence in an Older Community: The Dubbo Longitudinal Study of the Elderly 1988-2003.

[17] Nygaard I, Gitrs T, Fultz NH, Kinchen K, Pohl G, Stemfeld B, (2005) Is urinary incontinence a barrier to exercise in women? Obstetrics and Gynecology 106(2): 307-314

Improving outcomes for older people

This project has received overwhelming support from a wide range of stakeholders, including older people who say that this is a neglected issue and of great importance in helping them to maintain their dignity and independence.

Comments from older people and people who have experienced incontinence from a report commissioned by Help the Aged on the link between incontinence and social isolation point to the misery that this condition can involve and the huge personal benefits that can be achieved for individuals when incontinence is properly treated:

- "I mean, when once you've got control of it, you know life would be so much different".
- "It's a bit worrying sometimes but it's not as bad as it was. I couldn't have gone this time last year, no way. But I think I could manage coach trips. I could manage a coach trip now"[18]

Impact on performance (levels of complaint, legislative challenge, adverse media etc)

- **Positive** – Continence is a neglected area in Oxfordshire and elsewhere. The current service does not comply with national guidelines, but will do so following transformation.

Impact on staff & carers

- **Positive** – Incontinence is known to be the "final straw" for carers struggling to cope, but also for people working in the care system, such as care home workers. By tackling the issue, improving the service and availability of simple low cost treatments, we can help social care staff and others to be part of the solution and make a real difference to older people who experience incontinence.

Impact on Reputation

- **Positive** – John Bolton (former director of strategic finance for social care at DH) said of the Continence Services Redesign Project: "Your work on incontinence places you as a national leader in this field and others have much to learn from your joint working". More recently, DH South East have indicated that the project has been commended to the Care Services Minister Paul Burstow MP as an example of how efficiency savings can be achieved without cutting services.

Timetable for Change

- Business case, approved July 2010
- Year 1 priority programme agreed, July 2010
- Go Live, new induction course content for new social care workers, October 2010
- Awareness campaign targeting existing social care staff, TBC, likely late Autumn 2010

Risk Analysis

- PCT (and it's successor arrangements) need to sustain commitment to transforming the Bladder & Bowel Service if full benefits are to be realized
- Resources may need to be allocated to develop and support awareness raising among new and existing social care staff – likely to be minimal and there are opportunities to work with other initiatives, eg. SDS workforce development

[18] All quotations taken from Godfrey, H, Hogg, A, Rigby, D, Long, A (2007) Incontinence and Older People: Is there a link to social isolation? Research and report commissioned by Help the Aged.

Service Area / Development	***Mobile Adult Services Centre***

Brief Description of Change and Impact of Change

Develop and implement a Mobile Adult Services Centre

The Health & Wellbeing Partnership Board requested at its meeting in June 2010 a paper setting out the business case for developing a Mobile Adult Services Centre (MASC) for Oxfordshire. This request followed a presentation to the Board by Marie Seaton, Interim Head of Joint Commissioning for Older People, which suggested that Oxfordshire might put in place an MASC, based on the existing Oxfordshire Mobile Children's Centre, which could deliver a range of different information, advice and services aimed at older people that would promote health and wellbeing and would also address older people's concerns about access to services in rural areas and problems with transport.

It is now proposed to develop and implement in 2011/12 a MASC, subject to the successful completion of a short pilot project utilizing spare capacity in the winter months on Cherwell District Council's and Oxfordshire PCT's Health Bus. Partner organizations are enthusiastic about this proposal which would quite literally provide a vehicle for drawing together a range of different services and issues broader than just social and health care. It could also act as an enabler for changes and efficiencies elsewhere, for example, changes to day services, and service developments which would help to ensure that the most isolated and vulnerable people in our society still receive help and advice. The purpose of the MASC would be to provide to vulnerable, isolated older people in both rural and urban areas a range of information, advice and access to services, including:

Health information, advice and services	Staying active - community exercise and dance classes, health walks Advice on 'what exercise is right for me?' Continence awareness and help to self care Weight management advice and services Smoking cessation initiatives and support Advice on mental health issues Community based support for long term conditions Falls prevention advice and support Oral health advice, Footcare
Other information and/or advice	Welfare benefits and entitlements such as winter fuel payments Housing options, adaptations, minor repairs and security Transport options and advice Caring for another person and help available Cultural and learning activities, and other opportunities to develop or maintain social contact IT training and getting on the internet Community safety advice and support, eg. smoke alarms, advice on dealing with bogus callers Staying independent Advice on use of technology for staying independent

The MASC could also create an opportunity for older people who are isolated to meet others in their community, and could also have a positive, reciprocal relationship with other community facilities, such as village halls, and community initiatives, such as lunch clubs, exercise classes etc.

Evidence of need includes:

- Key messages from consultations with older people since 2007[19] suggest that older people want more and better information to "make choices real"
- Nearly 20% (c.18, 675) of over 65s live in areas in the bottom quartile for areas with geographical barriers[20] to services in Oxfordshire.
- Over 46% (c.43,400) of over 65s live in rural areas, over 22% (c.21,000) live in very rural areas[21]
- 39% of social care referrals come from rural areas, 18% from very rural areas
- 41.8% of Attendance Allowance claimants (c.6,100 people) live in rural areas, 20% (2,910 people) live in very rural areas[22]
- 6% of poor urban households were are in fuel poverty, 11% of poor rural households are in fuel poverty, 16% of poor very rural households are in fuel poverty[23]

As with other public health and wellbeing initiatives it is difficult to quantify the benefits and potential savings from this initiative. The pilot should help to establish how this initiative can:

- Improving access to information and essential services
- Help vulnerable older people to make informed choices
- Improve outcomes for older people – eg, through the take up of benefits such as Attendance Allowance etc.
- What savings, if any, could be attributed to and evidenced by the continued provision of the service

This initiative should also be seen as part of a broader, menu-based approach to preventative services. A business case on what is needed to promote and sustain older people's independence in Oxfordshire, and how our approach needs to change is being prepared and will be presented to the Health & Wellbeing Partnership Board in September.

Improving outcomes for older people and their carers

This initiative will enable vulnerable and isolated older people and their carers to access key information and advice that will help them to make informed choices about their health and wellbeing and to access services and support that will help them to maintain their independence.

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[19] *Ageing Successfully – Forward from 50 – NHS Oxfordshire & Oxfordshire County Council, 2010. Sources include: 'Design Day' February 2009 Oxfordshire's approach to SE Regional Initiative to support independent living for older people with high support (event with 80 people; Engaging Older People in Oxfordshire Oxfordshire Rural Community Council for Oxfordshire Primary Care Trust (569 people involved); A fundamental service review of day services for Older People 2007 Oxfordshire County Council (survey and focus groups day centre users)*

[20] Geographical barriers are assessed using an algorithm based on distance from shops / schools / GP surgeries etc.

[21] 'Rural' is areas defined by ONS as 'Town & Fringe' and more sparse. 'Very Rural' is areas defined by ONS as 'Village Hamlet & Isolated Dwellings' and more sparse (see attached map for areas in Oxon falling into these categories). Over 65s number are taken from people claiming state pension (DWP site - from Nov 2009)

[22] DWP Nov 2009

[23] Based on NI187i figures, based on surveys conducted by USEA for the districts

Impact on performance (levels of complaint, legislative challenge, adverse media etc)

- **Positive** – the initiative is likely to be well received by local communities and older people, particularly in areas where key services are less accessible or have disappeared, e.g. Post Offices. The 'Health Bus' is a tangible, visible and potentially "media-friendly" example of how partners are working together to improve services for the most vulnerable in our society

Impact on Staff

- **Positive** – as part of a broader, "menu" approach to preventative services in Oxfordshire, this service could help to ease pressure on essential health and social care services by helping older people to exercise informed choices that will help them to remain independent for longer

Impact on Reputation

- **Positive** – See 'impact on performance' above

Timetable for Change

- Outline business case and recommendation for pilot, to be approved by Health & Wellbeing Partnership Board, September 2010
- Pilot completes, March 2010
- New service rolled out countywide, subject to successful pilot, approvals and funding allocation, April 2011

Risk Analysis

- Nothing to highlight at this stage

Rachel Lawrence
Service Manager, Promoting Independence & Prevention
Social & Community Services
2nd September 2010

Ageing Successfully Work Programme: September 2010

Title	Project	Key Tasks	Action completed	Expected to Impact	Status
1. Primary Prevention **Universal Services**	**1.1 Community Building**	IPC commissioned to: • report on best practice and community building; • Deliver a community development forum • Deliver community development training Reported back to Directorate Leadership Team and Project Brief developed. The Project will focus on defining a framework for investment into community building to support vulnerable adults and produce support materials to target and help communities support vulnerable adults. Evaluation of the Good Neighbour and Volunteer Scheme has reported and an opportunity to develop a county wide delivery model to complement the work on Day Services is under consideration.	August 2010 August 2010	March 2011 March 2011	Green
	1.2 Public Health prevention initiatives	• 'Get Oxfordshire Active' a 3 year project working in partnership with all five local authorities to provide more community based exercise classes and health walks established under the existing partnerships of GO Active, district councils, Age UK, County Council and Oxfordshire's Fall Service. (PCT investment £85,000 GO Active p/a). • Exercise on Prescription: Referring eligible patients with low-medium risk medical conditions to discounted exercise. Eligible people are referred by their GP to their local leisure. Approximately 340 people over the age of 50 access the Oxfordshire Exercise on Referral Scheme every year many more are supported by Cardiac Rehabilitation services • New exercise for older people service • Mental Well being programme • Healthy Eating programme and work with trading standards to develop a healthy eating "scores on the doors".	April 2010		Green
	1.3 Age Proofing	Age-proofing across services and promotion of activities to 50+ age group, as prevention and early intervention activities involve a range of public, private and community services	September 2010	April 2011	Green

Title	Project	Key Tasks	Action completed	Expected to Impact	Status
		leisure/libraries/community development etc. Progress report to H&WBPB on 16th September to include information on • Developing a toolkit; • Proposals for awareness training • Audit of existing services.			
	1.4 Adult Mobile Centre	Improving access to universal information advice and support services a high priority. Models developed within the POPP and LinkAge Plus programmes. A model of an integrated mobile unit in partnership with the districts, voluntary sector, libraries, public health and social care to promote health and well being under development. An options report for an Adult Mobile Centre will be presented to HWBP Board 16th Sept.	March 2011	April 2011/ 12	Amber
2. Targeted Prevention	**2.1 Transport Strategy Review**	To determine opportunities for an integrated approach to transport across health and social care. Transport requirements under review in context of Personal Budgets and day services review.	March 2011	April 2011/ 12	Amber
	2.2 Turnaround Project	Turnaround is a new approach to promoting independence. It aims to identify people who may be on a pathway towards high dependency and residential care, and turn them back. The concept has emerged from work led by Adult Social Care and involving the Institute of Public Care (IPC) which identified a potential target group of people who may be on a pathway towards long term residential and nursing care, who could potentially be 'turned back' - if they are identified soon enough and offered support that is 'right' for them. This work also applies to those at risk of hospital admission Development of a Predictive Modelling tool and business case to Prevention Steering Group 9th Aug to risk assesses and turnaround individuals from high cost residential and nursing home care. Screening EARLI tool to be tested with key stakeholders. Progress report to H&WBPB on 16th September.	Oct 2010	Dec 2010	Amber

Title	Project	Key Tasks	Action completed	Expected to Impact	Status
	2.3 Day Services Review	Service model proposes Health and Well Being Centres along with universal and preventative services that will focus on information, employment opportunities, education, volunteering, community and social activities. Consultation underway on the Service Model. Opportunities to link with and extend the Good Neighbours Scheme part of the review. An integrated approach to see how Day Hospital services complement the future development of Day Services is also under consideration. Investment £4.606m includes internal and external provision and transport. 35% of the service element will be allocated to the Resource Allocation System (October 2010).	April 2011	TBC	Amber
	2.4 Falls	To improve the falls care pathway for non conveyed fallers picked up by South Central ambulance crews. Through falls assessment and identification of services/interventions to reduce risk of future falls. • 40% admitted to hospital after first fall call out; • 28% in the first month Pilot in Didcot to assess effectiveness and value for money and a business case developed that proposes a roll out across Oxfordshire.	April 2010	April 2010 building for 1 year	Green
	2.5 Exercise Programme for Older People	Exercise on Prescription: Referring eligible patients with low-medium risk medical conditions to discounted exercise. Eligible people are referred by their GP to their local leisure. Approximately 340 people over the age of 50 accesses the Oxfordshire Exercise on Referral Scheme every year many more are supported by Cardiac Rehabilitation services. Investment £100k subject to review	TBC following investment review		Amber
	2.6 NHS Dentistry	Pilot reviewed the age groups accessing NHS dentistry on Oxfordshire linked to the refresh of the Oral Health Needs Assessment. Active older people and those reliant on state support under represented and had not seen an NHS dentist in the last 24 months. Work in residential care homes on the level of oral health need	TBC		Amber

Title	Project	Key Tasks	Action completed	Expected to Impact	Status
		has found a wide variation on what constitutes oral health care and how it is provided. CQC is developing oral health care standards for residential homes Proposed work to include development of domiciliary services and oral health training for care staff. The dental commissioning group aim to reach older residents of Oxfordshire and develop appropriate and accessible services to: • Improve availability and access to NHS dental services for older people • Ensure awareness of the dental helpline details through relevant groups via posters and helpline cards • Explore the use of other information sources used by older people with partners e.g. DigiTV • Improve knowledge of oral health for carers working in residential care settings using developed channels • Develop service specification for a domiciliary service for patients in care home settings or their own homes who are unable to attend a local dental practice, with a particular focus on denture treatments.			
3. Whole System Pathway Redesign	**3.1 Stroke**	Mean Length Of Stay (LOS) at the John Radcliffe (JR) reduced from 24 days in 2008 to 4 days now. Change of use of community hospital beds Reduced LOS community hospitals Improved outcomes for patients Reduced use of Oxfordshire Centre for Enablement inpatients. Have early supportive discharge as a pilot Made cash savings by tariff work Investment 164k Forecast payback at current activity level £730k for 2010/11	May 2009	2009/10 ongoing	Green
	3.2 Fractured neck of femur pathway JR	Reduce LOS in 80% people at JR to less than 10 days Reduced LOS in community hospitals to 14 days Increase skills and knowledge in community hospitals to manage surgical cases from 2 days post op	July 2010	Start August 2010	Green

Title	Project	Key Tasks	Action completed	Expected to Impact	Status
	3.3 Fragility fracture pathway	New pathway for deflecting admission to acute bed, reducing in-patents LOS Secondary prevention to prevent further fractures and reduce the need for individuals to enter care homes or be reliant on high intensity home care packages Pathway commenced July 19th with review in November, when expect to go to stretch targets and become a formal contract variation. Unbundling the tariff HRGs 11-14 at 10 days to release £250k-400k annually. S&CS modelling the savings to social care based on the Dept of Health 'Economic Evaluation' 10 hip fractures averted cost saving to social care of: 0.9 care home placements. Working assumption each care home placement is for 2 years at £600 per week; total costs £37,440 over 2 years for 10 hip fractures or average £3,744 per hip fracture Plus 3 home care packages based on 6 out of 10 hip fractures discharged from hospital back to their own home requiring a home care package and 1 in 2 eligible for social care funding. Combined value £3744 + £135	December 2010	Start January 2011	Green
	3.4 Dementia Pathway and additional projects to implement strategy	Single point of access/triage for early diagnosis to reduce overall long term care costs. Investment £116k. To improve quality of care for patients with dementia and stop extended LOS for those with dementia. Business case based on Dept of Health national evaluation found: • 6% reduction in the number of people with dementia entering care homes would result in savings for Oxfordshire of £1.62m • 10% reduction would result in savings of £2.7m • 20% reduction would result in savings of £5.4m	December 2010	April 2010-12	Green

Title	Project	Key Tasks	Action completed	Expected to Impact	Status
	3.5 Continence services redesign	To improve hospital care, reduce in-continence; to speed up recovery and deliver an integrated county wide service and approach .The front line workforce will be up skilled, to reduce dependency, size of packages and entry into care homes. Reduce infection rate in community and prevent admissions Investment 100k 2010/11 Potential cashable savings 119k Non-cashable savings stopping one care home placement 30k; reduction of one visit a day for 50 people annual reduction £182,500	October 2010	December2010-12	Amber
	3.6 Carers Support	Supporting Carers is vital to promoting the independence of older people. Initiatives included: • Commission 'carer's awareness training' to be delivered to 82 practices, District Nurses, Health Visitors, School Nurses and Community Hospital staff. Training delivered through outreach to consortia and other network meetings with 10 centralised training events to target the frontline health staff in community settings. • Targeted information and advice to support carers • An increase in investment in carers' breaks to encompass increased use of direct payments/ more flexibility for the user. • Rationalisation of the Befriending service to take appropriate account of good neighbourhood schemes which are developing across the county • Carers' support service to include the delivery of culturally sensitive services by maximising existing resources within the Community Development Team and PCT • Increased investment in the Emergency carers' support service • Support carers to take up employment, education or training and to facilitate this by widening the take up of direct payments • Awareness and reach out work to increase numbers of carers who do not currently access services, information and advice.	December 2010	January 2010 ongoing	Amber

Title	Project	Key Tasks	Action completed	Expected to Impact	Status
	3.7 Whole System Community Bed Based Strategy	To have a joint health and social care strategy to the use of all bed based stock: • to improve value for money • identify efficiency savings • make best use of existing resources **ECH Programme** by end 2011 296; additional capacity 210 end of 2012. Target for ECH provision to replace 66% of S&CS funded places purchased in residential care. Estimated £1.4m savings by 2014/15 assuming 463 ECH places in operation. Subject to further work due to OCC requirement to find efficiency savings over the next 3 years. **OSJ Contract** Stage 2 8 homes for negotiation of redevelopment of services. Total cash value of contract £513m, of which £365m represents OCC purchasing, reduces to £303m after resident contributions. Proposal development stage plans reviewed to ensure future-proofing is maximised.	March 2011	April 2011/12	Amber
4. Alternatives to acute admissions	**4.1 Hospital at Home Care (sub acute)** **4.2 End of life rapid Response**	Greater system flow, reduced queues, reduction in delayed transfers of care.	October June 2010	June 2011 June 2010 building over 1 year	Amber
5. Rehabilitation	**5.1 New rehabilitation model** **5.2 Access and Enablement Service**	Development of a model for rehabilitation a function rather that a discrete service. It incorporates a wide range of different services/interventions along a pathway spanning acute and long term care, linking with social care and reablement. The model will translate into a service specification. Model presented to JMG August 13th. Specification and contract will follow on from the model for rehab. 28 day LOS by October 2010 reduced queue for service. Service Spec in place from 1st October	September 2010	September 2010 building to end of 2010/11	Green

Title	Project	Key Tasks	Action completed	Expected to Impact	Status
		Business case to JMG 13th Aug and H&WBPB 16th Sept Increased productivity/efficiencies through maximising the two components to see 8,000 cases per year. Costs for 4 week packages Reablement= £865 Rehabilitation= £374 Combined packages= £1212 Comparative costs for 4 weeks Acute hospital £9520 Community hospital £6552 Care home £2600			
6. Reablement	**6.1 New Reablement Model**	Remodelled 'home care' services to: • Encourage individuals 'to do' rather than' doing it for' them • Focus on practical outcomes within a specified timeframe • Individuals with poor physical or mental health are helped to accommodate their illness by learning or re-learning the skills necessary for daily living. Reablement seen as a positive model and longer term implications still emerging from evaluation.	October 2010	April 2011	
7. Long Term Care	**7.1 Telecare**	4 contracts awarded and service available to 5000 users; 1500 users to use emergency response and 200 access planned support. Evidence from early evaluations of telecare interventions reveal significant savings around emergency hospital and residential care admissions. Beneficial impacts: • Increased choice, autonomy, control and independence. • Improved quality of life. • Maintenance of ability to remain at home. • Reduction of demands placed upon carers. • Improved support for people with long term conditions • Reduce accidents and falls in the home. Whole Systems Demonstrator to report late 2010 on contribution of telecare to cost and clinical effectiveness; patient and carer	April 2010	2011 ongoing	Amber

Title	Project	Key Tasks	Action completed	Expected to Impact	Status
		quality of life; and the everyday practices of health and social care professionals.			
	7.2 Telehealth	Project will provide equipment that is simple to use and enables people with respiratory and heart conditions to monitor their vital signs on a daily basis to send their information to a clinician, to receive advice, and to be prioritised for appropriate treatment and interventions. Capital £243,350 Revenue £196,650 2010/11 and 2010/11. Bicester North, South, West and Thame have estimated 1380 older people over the age of 75 and 460 live alone. Introduce digital technology to this cohort.			
	7.3 Use of equipment and technology	Cost Benefit Analysis of equipment use and technology versus alternative support and institutional care.	TBC		Amber
	7.4 Medicines Management	Improve medicines management within care homes through targeted intervention. Completing medicine reviews on people over 65 taking 4 or more medications leads to a small reduction in morbidity and significant reduction in falls. Patients who have had a medicine review are 60% less likely to fall than those without a medicine review.			Green
	7.5 Case Management Case Management in Care Homes	Greater system flow, reduced queues, reduction in delayed transfers of care Improve healthcare of older people in care homes and reduce non-elective hospital bed day admissions by 26%.	August 2010	August 2010	Amber
	7.6 Disability Facilities Grants	Access to funding for improvements to people's own homes has scope to promote autonomy, to prevent illness and to reduce demands on both families and formal services • Delays in processing DFG applications has the potential to increase the need for intensive social and health care services, delayed transfer from hospital and entry into residential care • One year's delay in providing an adaptation to an older person costs up to £4000 in extra home care hours	July 2010	April 2011 ongoing	Amber

Title	Project	Key Tasks	Action completed	Expected to Impact	Status
		• Postponing entry into residential care by just one year through adapting people's homes saves £28,080 per person. • Demand for DFG's is likely to increase because of the ageing population and evidence may show the DFG's are effective in preventing or delaying the need for intensive social and health care services. • Engaging the districts to identify what action to speed up delivery and improve performance. Investment of £250k being used to recruit 4 Occupational Therapists to work in all district housing offices			
	7.7 Social Care Review Accelerated reviews home support cases	Set up "Accelerated Review Team" of 3 experienced social workers for internal home support clients Objective to reduce 15 minute calls and double handed packages. Aim for 4 reviews a day	July 2010	July 2010	Amber
	7.8 Menu of prevention services (TASC)	Low-level practical support initiatives can significantly affect the health and well being of older people and achieve better outcomes- both in terms of lower use of formal services and institutional forms of support. Menu of prevention services being complied to take to JMG September 2010	Sept 2010		Amber
	7.9 Personal budgets in health	• Personal Health Budgets work plan and deliverables confirmed. NHS Oxfordshire is one of the 20 fully evaluated national sites participate in the national pilot of Personal Health Budgets in Continuing Health Care. • Development of the blue print for Personal health budgets in Oxfordshire for any care group • Direct Payment pilot site	July 2010	July 2010-12	Amber
	7.10 Personal budgets in Social Care	Individualised forms of funding aim to achieve better outcomes for individuals, meeting needs more fully and enabling people to remain living independently. Outcomes from pilots; • Improved satisfaction levels for people who use services • Improved use of resources • Increasing use of community and personalised support	October 2010	October 2010 ongoing.	Green

Title	Project	Key Tasks	Action completed	Expected to Impact	Status
		From 1st October 2010 all new referrals to adult social care who meet the eligibility criteria will be offered a personal budget.			