Ageing Successfully: Forward from 50

Oxfordshire's Strategy for Ageing

2010-2015

NHS Oxfordshire and
Oxfordshire County Council

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1. INTRODUCTION

Our Commitment

"We celebrate the fact of our ageing population. We want all people as they age to lead lives that are healthy and personally and socially fulfilling. Our mission will be to achieve significant and measured improvement in how we plan and deliver services so that our community will be supported to age successfully."

Oxfordshire Health and Well Being Partnership Board
March 2009

Working together through the Partnership Board, Oxfordshire County Council, NHS Oxfordshire and their public, private and third sector partners have made this ambitious commitment as part of their plans for the future of our community. This strategy document now describes our vision for future services and the basis upon which we will approach its implementation.

The proposals we have set out lay the foundations for ensuring we have sustainable, high quality and accessible services and opportunities in place for the growing population of older people in Oxfordshire. Much of this support will be provided in the community outside acute hospital and residential care settings.

In devising our plans we have moved away from a fixed, single definition of what constitutes old age to one that is based on the needs of people as they get older. Our strategy is based on the aspirations and ambitions of people who anticipate many active years and fulfilling lives after their 60th year; the evidence of the benefits of a range of preventative and health promotion services to people as they age through their 50's and 60's; and the reality of increasing frailty that has an impact on many people as they age beyond 75.

'Ageing Successfully' is focused on keeping people well (prevention). It seeks a shift in investment away from acute hospital care to health promotion, preventative approaches, primary care, integrated community services, early intervention, and rehabilitation. Our approach is to shift the emphasis away from providing services 'for' people towards ensuring more active participation in lifestyles which aid well being and good health while ensuring those who need specialist or long term support receive it. This means more people will access universal services available to all, while some services will be targeted to those who are eligible.

The natural effect of ageing means that the likelihood of ill health increases with age. Promoting healthy approaches to ageing is therefore a major part of 'Ageing Successfully'. This includes encouraging physical exercise and creating healthy workplaces along with a focus on preventing ill health through early intervention. Helping people in mid-life to adopt better ways of living will minimise health inequalities and ensure future generations of people ageing in Oxfordshire are the healthiest yet.

Implementing a model based on enhanced prevention, primary care, early intervention, and integrated community services presents many challenges over the next five years. It means change on an unprecedented scale for individuals, organisations and communities. It will mean hard choices about resources and priorities.

In pursuing our strategy and making these choices we will:

- Involve older people who may use services and their carers
- Work with service providers to improve services in an orderly and effective way
- Work closely with partners in commissioning and delivering support
- Promote equal access to services that meet the diverse needs of older people living in Oxfordshire.

Working Together

The early development of the strategy was supported by work with the District Councils and Age Concern. A working group was established under the leadership of Cherwell District Council, which involved officers from the City and District Councils, Age Concern Oxford and NHS Oxfordshire, Public Health and the County Council. The group worked to get a full picture of the activities and services that supported or could support the vision and objectives of the high level strategy that had been agreed. This would shape and inform the final strategy. The working group identified and mapped the range of local services and activities provided through the City and District Councils, Public Health, and Age Concern. It provided baseline information on what is currently available across Oxfordshire that supports the objectives of Ageing Successfully.

Helping people to stay healthy and preventing ill-health requires partnerships between those commissioning and providing services. At a national level the Operating Framework for the NHS 2010/11[1] is clear that partnership is an absolute imperative in delivering radical approaches and innovation. It is necessary to achieve the transformation required to support people closer to home and reduce investment and activity in the acute hospital sector. Locally we recognise our goals will be only be met through working closely together to consider priorities and how the resources of each partner can best be used to meet local needs.

Primary prevention maintains and improves people's physical, mental and social wellbeing as they age. Oxfordshire County Council and District Councils with their strategic and commissioning roles in housing, leisure, cultural and environmental services will play an important role in leading primary prevention. This is built upon by local strategic partnerships, bringing together the police (community safety), GPs, NHS Oxfordshire, and the community and voluntary sectors. Their intention is to pioneer a significant cultural shift towards a more inclusive society, increasing people's ability to maintain their independence and exercise choice and control over decisions about their lives as they age.

[1] The Operating Framework-for the NHS in England 2010/11 Department of Health

The challenge and financial implications of an ageing population is a whole-system issue that goes beyond the boundaries of any one organisation (Appendix 1). As a result the financial plans of partner organisations designed to respond to the ageing population will need to be informed by:

- The Joint Strategic Needs Assessment (JSNA)
- Creating a Healthy Oxfordshire
- Oxfordshire Sustainable Community Strategy
- Relevant Local Area Agreement objectives
- District Council strategies and plans

A coherent, coordinated integrated planning framework will enable all partners to achieve strategic priorities. Lack of a joined up approach to strategy can lead to decisions that limit future options. A decision to close or reduce a service by one organisation could reduce other organisations future options for developing programmes to improve older people's well being and reduce health and social care costs.

We are committed to effective commissioning being developed in conjunction with major partners and through open relationships with suppliers and providers. The intention is for integrated commissioning strategies to be developed across adult health and social care, with older people and their carers where relevant. The involvement of key partners including the primary care, district and city councils, along with the voluntary and independent sectors, will produce comprehensive and effective integrated commissioning strategies. All partners will need to be involved in developing the Delivery Plans and Outcome Measures given the scale and complexity of transformation.

Our Strategy

The purpose of this high level strategy is to:

- Summarise our vision and the forces driving change in our approach to services for older people
- Outline the approach to commissioning services for people who are ageing and their carers over the next 3 years
- Set out our specific commissioning priorities for 20010/11
- Identify the key challenges that will inform commissioning in future years.

It is based on national and local research about what people want from services as they age supported by local consultation events and research into good practice. It aims to demonstrate what is known about the needs of older people and their carers, and how this influences joint commissioning intentions. It provides a framework within which a range of existing commissioning strategies will be reviewed or new ones developed and business cases for new investment considered.

2. OUR VISION FOR CHANGE

Our Vision for Ageing Successfully in Oxfordshire

Our vision is for Oxfordshire to be a place where older people thrive and feel empowered to live life as they want, controlling for themselves any support they need.

We recognise that as people age they:

- have a right to use the same services, resources and facilities as people in the wider community;
- should be central to decisions that have an impact on their lives and supported to make informed choices;
- must be able to live their lives safely and with dignity;
- should be supported to remain healthy for as long as possible
- need access to community based housing and support options to live independently;

Delivering this vision involves a comprehensive approach to ageing that addresses the needs of individuals in their 50's through to end of life. It will require a fundamental shift in focus away from treating the results of ill-health, acute hospital care and services that foster dependency towards primary care, keeping people well (prevention), health promotion and investment in personal care where people are helped to manage for themselves in their own homes.

Aims

In fulfilling our vision for Oxfordshire we aim to ensure that:

- People as they age have a quality life, based on healthy lifestyles, a significant reduction in health inequalities and the promotion of 'Active Ageing';
- Workers as they age are encouraged and supported to stay in productive employment and economically active for as long as they choose;
- The contribution that people make to society is maximised through the promotion of active citizenship, community involvement and the creation of inclusive neighbourhoods;
- There is a greater range of high quality, effective preventative approaches to support independence and an increase in the restoration of independence following illness and injury;
- There is an increase in self help, mutual aid and the promotion of material wellbeing and financial security for people as they age;
- More people with complex needs are able to participate in their communities;
- Access to good quality information and advice is increased;
- Services are person-centred, safe, effective, efficient and of a consistently high quality with safeguarding systems in place to protect people who are vulnerable as they age;
- There is a radical shift in the relationship between 'professionals' and older people being supported, with an enabling service culture being developed.

Outcomes

Our success will be judged by the outcomes we achieve in five key areas:

- Greater **engagement** of older people as valued partners in planning for a fulfilling life;
- Better **health and well-being** achieved through preventative, practical and self help services and support to prevent decline, maximised incomes and access to leisure, transport and social opportunities;
- Improved **ability to cope with critical points and transitions** through the availability of intermediate care and community support, avoidance of inappropriate admissions to hospital or residential care and timely discharge from hospital;
- Extended use of **community based housing and support**, enabling 1000 more older people to be supported at home; increases in the number of older people in supported living and better use of care homes;
- More effective **commissioning** for home based care through better information and knowledge;

Improving access to health services by increasing the commissioning of integrated whole care pathways that create a proportionate and appropriate shift of activity from hospital into primary and community settings will form a key element of transformational change in Oxfordshire. Service developments for older people aim to have clear pathways of care and service models for areas of high usage. Clear pathways based on best practice and national evidence improves quality and outcomes as well as delivering more effective and efficient use of resources[2]. Development of baseline data, including a range of targets, will enable progress to be monitored towards the achievement of our goals. The targets to monitor progress against outcomes, where they do not already exist, will be developed as part of our delivery plans.

Involvement and Engagement with Older People

In making this change of direction we have listened carefully to what current service users, their carers and the wider public have told us (Appendix 2). To aspire to the vision of world class commissioning in patient engagement, a budget was secured to carry out the engagement with older people. Oxfordshire Rural Community Council started work in March 2008, completing the final engagement event on May 28, 2008. In a number of consultations with older people and their carers there has been a consistent emphasis on the need for:

- Access to good information and advice
- Easy streamlined access to services
- Access to transport particularly in rural areas
- Timely support that maintains independence
- 24/7 flexible care that will enable support at home
- Flexible respite arrangements to ensure that carers can continue maintaining people at home
- Timely access to GP services
- Respect for personal freedoms.

[2] 'Improving care and saving money' Department of Health January 2010

As our plans develop we will continue to encourage the participation of service users and carers in the design, review and evaluation of services. Listening to what the public have to say and acting on their views is essential to providing services that are responsive and modern.

The Driving Forces for Change

There are many factors which are driving the changes we now propose. These include:

- The changing population of the area and its health and well being needs;
- Changing perceptions of lifestyles and expectations, improved knowledge and ideas about good practice and what works;
- Older people themselves saying they want more choice and control to manage their own care;
- Drives for excellence, increased efficiency and equity in the way that health and well being needs are met;
- The emergence of new organisations, cultures, contracts and technologies;
- The views and contributions of the private and voluntary sectors;
- Increased understanding of the vital role of carers.

Some of the key factors are analysed below.

A Changing Population

The Joint Strategic Needs Assessment predicts a large increase in the older population over the next few years particularly in the over 85's age group and especially in rural districts. It is estimated that in 2010 there will be nearly 15000 people aged over 85 and over 24000 by 2028. The increase in the numbers of older people will inevitably result in more people needing support to remain independent in later life. Further details are set out in (Appendix 3).

As a result of improved longevity and declining fertility there is also a profound shift in the overall structure of our population. People as they age are becoming proportionately more important for their contributions to local economies and communities, for the demands they make as consumers, and for their expectations as citizens. There is an increase in the number of relatively fit and active older people, many of whom are and want to continue to be active contributors in employment, in their families and communities. The Audit Commission states 65% of volunteers are aged 50 or over; 25% of carers are aged 60 or over and the support they provide may be worth around £22 billion a year- more than double the current annual expenditure on care services for older people[3]. They will have a crucial part to play in delivering our strategy.

Research suggests that the post-war 'baby boomers' generation will be better off and have different expectations, lifestyles and patterns of consumption, compared with their parents. Meeting their expectations will present a particular challenge to our plans. However, not all baby boomers in

[3] Carers Direct, Myths About Carers, NHS 2009

Oxfordshire will reflect this trend. Some people as they age are on low incomes and may experience poverty and exclusion in later life. A key part of "Ageing Successfully" will be to reach people in mid-life who may be economically disadvantaged earlier in their life course. By targeting this generation now, we can improve the wellbeing of the older population of tomorrow.

A Changing Policy Agenda

'Putting People First'[4] and the 'NHS 2010-2015' have set out a platform for a whole new system of service delivery which will involve new partnerships, new commissioning processes, rationalisation of existing and creation of new teams, new skills and more flexible ways of working. 'Putting People First' has clearly signposted the end of the present care management process as no longer fit for purpose in the 21st century due to changing demography, technological development and changing expectations from the public.

In 2009, the government produced two policy statements on issues related to the financial implications of an ageing population.[5] One focused on the well being theme and the positive contributions that older people can make to their communities. The second described options for reforming social care to meet future needs within expected resources.

This change in policy requires that resources shift to a more universal approach for all needing support in a market based economy of care, away from service driven crisis management or inappropriate admissions to hospital. The transformational process presents challenges and opportunities for all partners as they respond to a fall in demand for some types of provision, such as residential care, and work to expand capacity in others such as community support. It has implications for staff working across the whole system. A planned and managed Human Resources process will be required to ensure appropriate consultation and support to staff through the change.

The Need for Housing

Another major area of pressure for change is the development of housing choice for older people, as this contributes to the health, well-being and care needs of an ageing population. (See Building Stronger Communities) Three of Oxfordshire's five Districts (Cherwell, South and West Oxfordshire), as the housing authorities, have produced or are producing comprehensive housing strategies[6]. These are based on the JSNA, Supporting People, care home and Extra Care Housing data trends; improved information and an emphasis on maintaining independence. There has been consultation with older people and implementation groups are in place.

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[4] 'Putting People First' : a shared vision and commitment to the transformation of Adult Social Care Department of Health Dec 2007

[5] 'Building a Society for All Ages' Department for Work and Pensions 2009; 'Shaping the Future of Care Together' Department of Health July 2009.

[6] 'Cherwell's Housing Strategy for Older People 2009-2014, Cherwell District Council January 2010;'Older People's Housing Strategy' South Oxford District Council Summary Report V3 November 2009

Saving Public Money

Public sector spending will reduce over the next few years and savings are required. The emphasis will be on avoiding spending and achieving greater value across all public services, including health and social care.

In 2009/10 the NHS in Oxfordshire had a budget of £850 million for the provision of services to residents of the county. In 2010/11, the Primary Care Trust will receive an extra £40 million and no increase at all for the next three years. However, costs will increase as will the demand for services. It is estimated that Oxfordshire's health system needs to make savings of £80 million a year for the next three years- a total of £240 million. As a whole system in Oxfordshire we need to improve the quality, productivity and value for money of health and social care services in a way that will keep us in financial balance and provide opportunities to invest in a wide range of services and approaches to respond to the changes in the population of Oxfordshire.

The scale of the challenge is enormous - demographic and health projections show that by 2014 additional services above the current levels will be needed as follows:

- 5,500 Acute care interventions such as operations or hospital stays
- 92,000 Patient appointments at GPs and Primary Care centres
- 13,000 Outpatient appointments

In order to deliver the scale of change necessary the NHS with key partners is committed to the Creating a Healthy Oxfordshire (CAHO) programme to drive improvements across the whole system. Six work streams were set up:

1. Integrated Community Service Provision	2. Shaping the Future of Primary Care
3, Acute Sector	4. Integrated Commissioning
5. Self Care and Patient Responsibility	6. Disinvestment

The work streams report to the CAHO Programme Board on work plans and progress. This provides a forum for the collaboration of health and social care strategic planning. This will ensure the development and delivery of the strategic plan for Oxfordshire in light of financial constraints.

A strategic approach is needed to recognise that spending from other budgets will lead to savings in health and social care. 85% of older people do not use council care services[7]. They may use other services, such as housing, leisure and adult education that play an important role in keeping them active and independent. Commitment and investment directed to keeping older people healthy and maintaining their independence at home will contribute to the savings Oxfordshire County Council and NHS Oxfordshire have to achieve over the next five years- £53.3 and £240 million respectively. However, the argument for primary prevention is often weakened by difficulties making a clear financial case. There are complex relationships between low-cost

[7] 'Under Pressure' Audit Commission 2010

prevention activity and future long term savings or delayed spending in higher cost health and health and social care services. Evidence is now available that spending on prevention can be linked to savings in health care.

A systematic appraisal of studies that evaluated health and social care from an economic perspective has found that integrated early intervention programmes can generate savings between £1.20 and £2.65 for every pound spent[8]. The Kaiser NHS Beacon sites have improved services as a result of working closer together. For example, one area has reduced its use of acute clinical beds for emergency admissions of older people, virtually eliminated delayed transfers of care, and improved access to intermediate care[9].

The evaluation report of the Partnerships for Older People Projects (PoPPs)[10] showed care spending on older people fell by £2,166 per person per year after using preventative services, while individuals reported better outcomes for themselves. For every £1 spent on PoPP services, £1.20 was saved in spending on emergency hospital beds. PoPPs supported 470 projects and benefited more than 250,000 people. More than 70% provided low-level services to help older people maintain independence, such as handyperson schemes, with the rest providing targeted support to those at risk of hospital admission, including falls avoidance schemes.

The Audit Commission states that small investment in services such as housing and leisure can reduce or delay care costs and improve wellbeing. Early intervention can improve wellbeing and save money. One county saves £1 million a year on residential care costs by providing telecare services (North Yorkshire)[11].

In Oxfordshire we must follow these examples and set ourselves challenging targets to ensure we save public money wherever possible and deliver the best possible value for money in supporting older people.

3. BUILDING STRONGER COMMUNITIES

'Ageing Successfully' is based on a belief that a strong local identity and sense of place provides all residents with the best possible chance of health, wellbeing and social inclusion. It is important this continues as people grow older through the creation of 'lifetime neighbourhoods' which offer an accessible and inclusive environment for people of all ages and abilities.

This section sets out our approach to ensuring that we develop such communities successfully in Oxfordshire. It describes a sample of the current range of initiatives in the county, outlines the work being done to develop our

[8] Turning Point Centre of Excellence in Connected Care, 'Benefits realization: assessing the evidence for the cost benefit and cost effectiveness of integrated health and social care', February 2010
[9] Ham C, 'Working Together for Health: Achievements and Challenges in the Kaiser NHS Beacon Sites Programme, University of Birmingham, February 2010
[10] 'Improving care and saving money' Department of Health January 2010
[11] Audit Commission 'Under Pressure' February 2010

infrastructure effectively, and summarises our current priorities for further investment.

Defining Lifetime Neighbourhoods

A 'lifetime neighbourhood' is a place where a person's age does not affect their chances of having a good quality of life. It is designed to be welcoming, accessible and inviting to everyone regardless of age, health or disability because the services, infrastructure, housing, and public spaces are designed to meet everyone's needs.

A number of factors such as good paving, street lighting and access to suitable transport services, seating and toilets make local neighbourhoods and towns accessible to older people and people with impairments. Providing a safe and inviting outdoor environment and access to green space or community gardens encourages people to go outside, take exercise and offers increased opportunities for social interaction. Whereas fear of crime, poor infrastructure design and a lack of access to services can 'disable' people in their homes or immediate environment and act as a barrier to participation in local activities.

Our plans to achieve stronger communities must encompass a wide range of policies and investments being implemented by a number of agencies working closely together. They must build on the 'Oxfordshire 2030,' strategic objective to achieve Healthy and Thriving Communities which includes pledges to:

- Improve support and opportunities for independent living.
- Promote healthy lifestyles including the increase of physical activity
- Protect access to local services particularly in rural communities
- Tackle crime and anti-social behaviour – particularly where the cause is the abuse of alcohol or other substance misuse.
- Work to prevent all forms of extremism that threaten the well-being of local people and communities
- Work with local people including the voluntary, community and faith organisations and the military to sustain and build supportive cohesive, resilient and well planned communities.

Current Position in Oxfordshire:
Housing

There is a well documented shortfall in suitable housing for older people within the county. This forms part of a wider need for an expanded housing stock to meet the needs of a changing population. The South East Plan requires that provision should be made for a total of 55,200 new homes by 2026. Oxfordshire is the most rural county in the South East region with over 50% of its residents living in settlements of less than 10,000 people. Increasing numbers of frailer older people are living in rural areas of the county often in oversized, older housing stock which has been designed and built without consideration of the changing needs that may arise overtime. The Joint Strategic Needs Assessment 2009/10 shows that in nearly one-third of cases (30%) where information about housing was available the person's current housing was not appropriate but only 12% had received adaptations to their homes.

Local District Councils are currently reviewing their housing strategies and planning policies to ensure that the needs of a growing and ageing population are met in a comprehensive way. Cherwell, South and West Oxfordshire districts have produced or are producing[12] housing strategies for meeting the needs of older people. District Housing Allocations Policies give priority to moving people where health and medical conditions make their present accommodation unsuitable and many older people receive assistance because of this policy**.** The priority is to work with the Districts, housing providers, the voluntary sector and older people to agree the process of involvement and links with existing strategies, for example, Adult Social Care Transformation, Ageing Successfully and the Extra Care Housing Programme.

The County Council approved an Extra Care Housing Strategy in July 2007. The strategy forms a vital part of the Health and Well Being Partnership Board's objective of supporting older people to maintain their health and independence in their own homes by promoting and supporting various models of new or re-modelled sheltered housing provision which will offer care, support and well-being services. The Extra Care Housing Programme will deliver:

- Between 3,000 to 9,000 units of extra care housing, 2,600 of which will be for social rent and the remainder to purchase or part purchase/rent by 2026
- An average of 10 hours personal care delivered for two thirds of residents, i.e. delivery of 20k to 60k hours of care per week by 2026 funded by both private and Council payment
- Schemes in urban, market town and rural areas according to needs at preferred average size of 50 units per scheme
- Substitution and or replacement of most residential care homes and reduction in some nursing home and sheltered housing
- Modern assistive technology in new schemes.

The strategy will reduce use and expenditure on care homes, increase the number of older people helped to live at home, increase the availability of 'intensive home support' packages, and increase the supply of extra care housing compared to other Local Authorities. It will also increase the supply of affordable housing and specialist housing for older people to purchase thereby freeing up under-occupied private housing stock. The ability of older owner-occupiers to purchase extra care housing flats should allow 'equity release' that in turn allows more people to fund their own care and support rather than depending on the Council. Extra care housing also promotes independence and choice and by reducing social isolation increases wellbeing and health. Purpose built housing also makes care delivery more efficient and effective and has proven advantages for improving health outcomes and reducing hospital admissions and length of stay.

The Extra Care Housing strategy provides a major opportunity for cost substitution within revenue budgets. Supporting the care needs of an older

[12] 'Cherwell's Housing Strategy for Older People 2009-2014, Cherwell District Council January 2010;'Older People's Housing Strategy' South Oxford District Council Summary Report V3 November 2009

person in an extra care housing scheme as a substitute for a residential care home will save approx £200 per week, as Social and Community Services fund only the care component in extra care housing. Accommodation and other non-care service charges are funded by housing benefit, other benefits, Supporting People or by residents own income. This contrasts to care homes where 75% or more of all costs are met by council funds for older people eligible for state funding. Replacing 500 to 800 residential care beds with extra care housing places could save £100k to £160k per week.

Increasingly, there is a requirement for all new affordable housing to meet '**Lifetime Homes Standards'** and for some of this provision to be of wheelchair standard where a need is identified. These standards include a number of simple features such as a level or gentle sloping approach to property, doors wide enough to allow wheelchair access, and sockets and controls at convenient heights. All new housing developments must increasingly meet accessibility and design standards with the objective of creating lifetime neighbourhoods. The provision of housing support in the form of Affordable Warmth grants, Disabled Facilities Grants, The Home Improvement Agencies , small repairs and home safety checks funded by District Councils and Central Government all enable older people to stay safe and well in their own homes.

Transport

Oxfordshire County Council is responsible for transport planning and is currently developing its Local Transport Plan (LTP3) for the next five years, which will come into effect from April 2011. The plan will support the delivery of Oxfordshire 2030 and help to meet a number of objectives including the promotion of healthy and thriving communities.

A range of consultation and research has been carried out both locally and nationally, looking at the needs of older people. During consultations, including an event in February 2009 in conjunction with the Office of Disability Issues, transport provision is still mentioned as an issue by service users indicating the plans have so far not been fully effective in meeting the needs of older people. The Office of Disability Issues has commissioned a project in West Oxfordshire (January 2009) to focus on transport options for older people with high levels of support needs. The result of this study will inform some of the detail of LTP3 and any supporting travel plans within rural communities.

The County Council is seeking wide consultation on its plan which includes support for community transport schemes, improving links with health services, providing staff with disability awareness training and encouraging walking and cycling as a mode of transport. The local strategy is to encourage people to use public transport as much as possible. In order to support older people to do this, all buses are being replaced with low-line buses (over 90% of routes now have low-line buses) which can lower the floor to make it easier for people to board and alight. All bus drivers in the county have attended disability training, which includes awareness of older people's needs, such as not setting off until people have sat down.

Current initiatives to make it easier for older people to get out and about include free bus passes and community transport schemes such as Dial-a-Ride, Volunteer link up and volunteer-run local community car schemes and community minibuses, Dial-a-Ride services and Volunteer Link Up are funded by Oxfordshire County Council and District Councils and the smaller community-based schemes are supported by Oxfordshire Rural Community Council's Community Transport Scheme and receive some grant funding from Oxfordshire County Council. Free transport is also provided by Social and Community Services for people with specific Health & Social Care needs but adequate transport options to access health care services remains an issue.

Communities

The development of sustainable communities which effectively meet the needs of older people is a significant challenge, particularly in more rural areas. High levels of mobility and car usage have shifted the supply of goods to centralised, more urban areas or shopping via the internet. The viability of local shops and Post Offices is under pressure from these changes in shopping patterns and service delivery decisions. These facilities are often a 'lifeline' in rural locations and highly valued by older people. In more urban areas social isolation and fear of crime need to be taken into account when planning for an ageing population.

District Councils have facilitated the development of inter-agency sustainable community and community safety strategies which support the development of local communities. These strategies reflect the local priorities within Oxfordshire 2030. Much of this work is developed in partnership with other statutory and non for profit organisations and governed by Local Strategic Partnerships. Priorities identified in these strategies will also be reflected in the Councils' own Corporate Plans which contains the details of how these aims will be delivered.

Current initiatives include:

- Community safety programmes such as Street Wardens, fire safety checks, neighbourhood watch and neighbourhood action groups (NAGs) and actions to reduce distraction burglary or reduce the number of cold callers help older people to **feel safe at home and when they go out**. This work is led by the multi agency Oxfordshire Community Safety Partnership, including Oxfordshire PCT, District Councils, Police, and Trading Standards.
- The County Council has a small annual budget for grants towards village hall and community centre building projects, **particularly those which improve accessibility.** The Council, together with District Councils, also funds the Oxfordshire Rural Community Council's Village Halls Advisory Service, with the help of which the grants fund is administered and which supports hall management committees throughout the county in achieving good quality halls offering a range of facilities in response to local need.
- Oxfordshire Rural Community Council works with rural communities generally to **improve the quality of life for those living in rural Oxfordshire** by strengthening community capacity and infrastructure i.e. by engagement & involvement in community-led planning, rural

transport projects and supporting community services such as local shops.

- Opportunities for engagement in social, cultural or learning activities and maintaining social contact **help to reduce social isolation and improve health and wellbeing**. District Councils**,** Oxfordshire Age Concern, Oxfordshire Rural Community Council and Oxfordshire County Council Community Services (libraries, heritage, adult learning, community development and arts) work with older people and local communities to establish and maintain local opportunities for older people to participate and to contribute as volunteers.
- Other examples include the library service engaging local communities and developing new relationships to support library provision and take up; a Heritage & Arts service project to enable older people to 'reclaim' alien public spaces in their communities through engagement in the arts; are development of a training programme for carers of those with dementia through the County Council's Adult Learning Service and Adult Social Care.

Citizenship and involvement

Maintaining people's involvement in local activities and encouraging involvement in local policy and decision making is essential to underpin the development of a sustainable and cohesive community infrastructure. Local groups, voluntary organisations, the church and neighbours are all valued by older people, and people can continue to contribute to the life of their local community by volunteering and participating locally.

Current work which encourages citizenship and involvement includes:

- The **'Adding Life to Years'** project to develop and support a sustainable service model which promotes the independence, health and wellbeing of people over the age of 50. The model includes building the community capacity and infrastructure to support the development of social groups and volunteer networks upon which preventative services such as exercise classes can link or work with
- Work funded by Oxfordshire County Council and led by Oxfordshire Rural Community Council supports the development of **'community led planning'** and there are good examples of parish, emergency and pandemic resilience plans.
- Statutory organizations have a duty to consult with local residents and ensure that the needs identified in local plans are integrated into the plans of relevant service providers and there are good examples of local services users **being engaged in the development, design and commissioning of services.**
- The **Good Neighbours Scheme** is a positive example of Oxfordshire County Council providing start up funding for local schemes around the county to recruit and support volunteers to provide small services for the more vulnerable in their communities.
- A programme of work led by the Oxfordshire Stronger Communities Alliance is increasing opportunities for **Volunteering**. Encouraging older people to volunteer brings about tangible **benefits in both physical and mental health, and extends opportunities for work and lifelong learning.**

- The Faith Research Project also led by Oxfordshire Stronger Communities Alliance will map the **contribution of faith communities** into volunteering, community assets and facilities and their involvement with wider community development issues.
- A COMPACT exists between statutory, Voluntary and Community Services and faith organisations, with principles around consultation, funding, equality and diversity.
- Local community led initiatives where the Community Development Teams in Oxfordshire County Council and Oxfordshire Age Concern support, for example, intergenerational programmes which enable **better understanding between the generations.** The provision of small grants by District Councils and the Oxfordshire Community Development Fund is aimed at helping small voluntary groups to serve their communities.

Information and Life Planning

Provision of timely, accurate information and ensuring good access to a range of services helps people to remain independent and feel they have control over their lives. At present older people report that they often stumble upon information, groups and services they need or value by chance. Existing provision includes:

- **Citizens Advice, Independent Advice Centres, Age Concern, Carers Centres, Oxfordshire Rural Community Council and County and District Council Offices and libraries** all produce and distribute useful information.
- A number of organisations, including **libraries and adult learning**, have improved access to and use by older people of information technology, and provide IT classes.
- Work to improve the quality and accessibility of information is being led by the **'Information project'** as part of Transforming Adult Social Care. This is focused on information provided by social and community services and needs to broaden to inclu**de information from ot**her partner organisations such as Age Concern and NHS Oxfordshire.
- **The Benefits in Practice Scheme** is now available at 15 primary care settings across Oxfordshire providing benefits and tax credits advice on prescription to those who find it difficult to get to advice centres in town centres.
- **The Inter Agency Referral Scheme** provides a chance for agencies to refer vulnerable older people to a range of help. In 2008/9 over 100 interagency referrals were made for fire safety, crime reduction, the falls service, home repairs and social and community services.

Planning ahead for old age, taking personal responsibility for managing long term conditions and adopting a healthier lifestyle are ways individuals can help themselves to live longer and fuller lives, and experience more years of good health. However, local consultations have shown us that people in Oxfordshire are reluctant to think about getting old and seldom prepare sufficiently for old age. This is an area of work that needs further exploration to identify ways in which we better support people in their mid and early later life to prepare for older age.

Economic Wellbeing and Paid Work

Having sufficient income and resources in later life enhances access to a good diet, transport, adequate heating and accommodation and participation in family and community life. People are living longer after retirement and without a reasonable level of income there is strong evidence that a person's quality of life, health and wellbeing will be compromised. At present 1.7 million pensioners nationally do not claim benefits even though they are entitled.

Existing local initiatives to help people enhance their economic wellbeing include:

- Age Concern Oxfordshire provide **information services** to support people as they age including a dedicated phone line which answers over 4,500 enquiries a year about benefit entitlements, financial and legal issues.
- District Councils support the **uptake of benefits and housing** support by offering benefit surgeries, home visits, joint visiting with housing associations and work along side Age Concern, the Pension Service and Carers Centres.
- The Citizens Advice Bureau **Financial Skills for Life** programme provides face-to-face financial education sessions on a range of topics, including preparation for later life. Available in 120 bureaux across England and Wales, the government aims to make this available across the country by 2011.
- A new programme of work funded by a Local Area Agreement reward grant from 2010 aims to extend **opportunities for paid work and phased retirement** by working with local statutory organisation and businesses.

Commissioning Priorities for 2010-2015

Priorities identified from a workshop with key stakeholders in 2009 include:

- Implement the District and Extra Care Housing strategies:
    - Extend the specialist housing and support
    - Improving the standard of housing
- Improve & extend transport options:
    - Ensure the needs of older people are taken into consideration in Local Transport Plans
    - Extend the provision of flexible, demand responsive transport services
    - Extend the provision of volunteer or other community transport schemes
- Retain choice and access by:
    - extending transport options (see below)
    - using community brokers as information improvers
    - better lit pavements, footpaths, benches and safe accompanying schemes
- Enhance people's local and social networks by:
    - improving community facilities (e.g. shop, hall, pub etc) and infrastructure
    - proactive 'case-finding' and outreach – to target those in greatest need

- Enable a ‘spark’ to happen within local communities:
    - Use a community development approach to encourage local people become engaged and get involved in volunteering or leading projects supporting their own communities
- Use community planning to create more local facilities:
    - Involve older people and community groups in the planning & development process
    - Ensuring the needs of older people are feed into the plans of all relevant provider organisations
- Improve community brokerage:
    - By implementing good practice from elsewhere
    - Developing systems to support local brokerage schemes
- Develop and support community groups:
    - Develop eligibility criteria and identify sources of grant funding for community groups
    - Providing information, training and advice to groups to become self sustaining in the long term
- Improve access to high quality information:
    - Exploring ways to ‘join up’ across organisations and sectors to improve access to information
    - Exploring improvement options such as a ‘single point of access’
    - Using community brokers as information improvers to ensure older people have relevant information when they need
- Retain and enhance people’s personal wealth and economic well-being by:
    - providing advice on employment and benefits take-up, making it culturally okay and normal
    - enabling people to stay in paid work for longer
    - developing community credit schemes

Priorities for development need to be agreed by all partners*.* Proposals for development, project initiation and implementation, will be the responsibility of the prevention work stream which will develop new proposals from April 2010.

Commissioning Intentions 2010/11

Projects already moving forward include:

- The Office of Disability Transport Project in West Oxfordshire will move into the action phase which will implement the agreed change initiative to help older people, with high level of support needs to live more independent lives. The evaluation of this project will help to inform the development of flexible, rural transport options in the future.
- Oxfordshire’s Affordable Warmth Network will be established with Local Area Agreement reward grant funding from April 2010, offering training to professionals and extending the existing grants programme across Oxfordshire. This will help older people who may be suffering from or be vulnerable to fuel poverty, keep warm during the winter by having increased access to improvement grants, benefits and insulation.
- Additional Supporting People funding has been awarded to Oxfordshire for a new handyperson service for two years. New services are due to be commissioned from 2010 with a view to extending help to older

people to maintain their gardens and carry out small repairs to their homes.

- Oxfordshire Stronger Communities Alliance has received £500k Local Area Agreement reward grant funding and is tasked to manage and commission a work programme to sustain and build supportive cohesive, resilient and well planned communities in Oxfordshire on behalf of the Public Service Board.
- Oxfordshire County Council has commissioned the Institute of Public Care to identify areas of good practice from 2010 and to help develop an evaluation framework. There will also be an evaluation of the Good Neighbour Scheme later in 2010 to understand the effectiveness of this project and how it may be developed.
- Oxfordshire County Council Information and Advice project being delivered by TASC will continue to improve the quality and provision of information from Oxfordshire County Council. This work stream needs to extend to include partner organisations and address the call for a more integrated approach to information provision.
- A new programme of work called **'***Age Proofing'* will aim to improve the access to services for older people from 2010. The purpose of age-proofing is to promote age-sensitive improvements in the planning and delivery of goods, facilities, services and environments for older people to support prevention and achieving and maintaining independence in later life.
- A new programme of work will explore extending opportunities for paid work and phased retirement by working with local statutory organisation and businesses. The same countywide workplace project called 'Workplace Wellbeing – making the most of work' will explore opportunities in workplaces support working carers and help them remain in work.
- An Exercise, Health and Wellbeing Advice Service will be commissioned by Oxfordshire PCT and Oxfordshire County Council to increase access to evidence based community exercise provision for vulnerable older people and facilitate community based health and wellbeing initiatives.
- A multi-agency agency project will aim to increase social care user's participation in sport and physical activity helping to create a healthier community with a reduced reliance on traditional forms of care. The project is exploring the potential of extending the S*upport with Confidence Scheme* initially into public leisure faculties, which could potentially be progressed in the voluntary and private sectors and into other preventive services such as culture. Training options are being explored to ensure consistent standards, but a resource would need to be found to audit service delivery to ensure these standards are consistently being delivered.
- Developing appropriate high-level outcome, performance measurements and targets for this work will require multi agency engagement and involvement. These will be developed under the older people prevention work streams and agreed by the multi agency 'Ageing Successfully Task force' from April 2010.

The implementation plans for this work will be developed under the older people work streams to be developed from April 2010. The emerging plans

will be subject to quarterly review and reported to the Health and Well Being Partnership Board and internal bodies such as the NHS Oxfordshire Board and Local Authority Cabinet as appropriate.

While we are developing our longer term plans for services and approaches to prevention, we intend to give priority in the coming year to the following initiatives:

4. TRANSFORMING PUBLIC SERVICES

Public services in Oxfordshire are undergoing transformational change through the CAHO Programme, Transforming Community Services, Putting People First Transforming Adult Social Care[13], and the Extra Care Housing Programme, whole system integrated care pathways, the Carers Strategy and development of personal budgets in health.

Creating a Healthy Oxfordshire's six work streams in particular will transform primary care, establish integrated locality teams, maximise internal efficiencies in the acute sector, develop integrated commissioning, integrate community services and develop self care initiatives to encourage people to take control of their own health and wellbeing.

The NHS Operating Framework for 2010/2011 (December 2009) gives a clear timescale for setting the 'future form' of community services. This is confirmed in Department of Health guidance[14]. By March 2010, NHS Oxfordshire has to agree in principle with the Strategic Health Authority its proposal for the future form of Community Health Oxfordshire A formal review process has started to develop a detailed service and business case with two local provider organisations. Core to the success of community services in the future will be the continued ability of organisations to work together to provide integrated services across pathways of care and focus on prevention and early intervention. Proposals for the 'future form' of community services will be tested against criteria which are consistent with the direction of travel for Ageing Successfully.

Transforming adult social care involves a clear direction for the next ten years. Making a strategic shift towards prevention and early intervention is one of the central objectives. There are four key areas that the County Council and partners are focused on to successfully transform services:

- The provision of general support and services available to everyone locally (universal services). This includes Transport, Leisure, Education, Health, Housing, Community Safety and access to information and advice;
- Support available to assist people who need a little help at an earlier stage to stay independent for as long as possible (Prevention and Early Intervention);

[13] Putting People First Transforming Adult Social Care Dept of Health October 2008
[14] 'Transforming Community Services: further guidance on the assurance and approvals process for the PCT proposals on community services' Dept of Health January 2010

- The development of self directed support. This means services that are more personalised. People requiring support will be able to choose who provides the services;
- Ensuring people are part of their community and thereby reduce social isolation.

The Putting People First Milestones

- By October 2010 approximately 1,150 new older people per year will receive a personal budget and will exercise choice and control over the way their needs are being met.
- By April 2011 approximately 3,850 existing older people who use services will have a personal budget to exercise choice and control over the way their needs are met.

Oxfordshire is currently on target to meet both these milestones. There are currently 350 people with a personal social care budget as part of the Learning Exercise that started in North Oxfordshire in December 2008. So far in Oxfordshire (mainly new recipients) we have seen:

- increases in the number of people choosing their budget as a Direct Payment;
- increases in the use of personal budgets and satisfaction that outcomes are being met;
- nearly all people worked with an independent broker to develop their plans, set up their services and choose non traditional services;
- people are purchasing services at a lower cost compared to the Council's purchasing activity.

Personal Health Budgets

Oxfordshire has been chosen as one of the major pilot sites for the testing of personal health budgets. During 2010/11 and 2011/12 Oxfordshire PCT working with the County Council will be piloting Personal Health Budgets in Continuing Health Care.

As people begin to choose services and support that meet their needs in a way that suits them best there will be major implications for the Council and the PCT in Oxfordshire. We can expect to:

Move away from….	**Move towards…..**
A 'provide and place service'	Individually tailored support
	Integrated whole care pathway
Block contracts	Individual contracts with a person
A focus on treating illness and ill health	Promotion of health, wellbeing and independence
Doing things to/for people	Enabling people to do things for themselves e.g. re-ablement, brokerage, advocacy
Commissioning for volume and price	Commissioning for quality, value and outcomes
Reliance on historical information	Use of real time data and analysis
Care for people with long tern needs	Focus on prevention, early

in institutional settings	intervention, self care and access to universal services
Service commissioning	Strategic investment
Commissioning by councils and the PCT	Commissioning at practice (health) and individual level (social care), use of personal budgets
Limited strategic, whole system planning and little flexibility in shifting resources	Flexibility in shifting investment to have greatest impact on current and future health and well being needs
Focus on inputs and processes	Focus on outputs and person-centred outcomes; evidence of choice and control
Provider led market	Market shaping
Generic support workers	Individually recruited supports

The level at which personal social and health care budgets will be set is critical. For the County Council this will be a public policy that will sit alongside the Fair Access to Care Policy and Guidance and will be confirmed in June/July2010. This will become a significant part of the budget setting process for the Council working with its key partners in future years and will start to have a major impact from 2010/11.

Priorities for 2010-13

2010/11	2011/12	2012/13
All new eligible people to be allocated a personal social care budget	All existing people to be transitioned to receive a personal social care budget	Review of implications of personal social care budgets
Publication by the Council of the Resource Allocation Policy and Guidance	Review of First Year of Personal Social Care Budgets	Review of Progress being made and options for extending Personal Health Budgets
Start of the Personal Health Budgets Pilot	2nd year of Personal Health Budget and review	Continued work on reshaping the supply market
Workforce Strategy and Plans being implemented	Continued work on reshaping the supply market	
Reshaping Supply Strategy		
Brokerage Contract to be confirmed		
Reconfiguring of contract arrangements		

5. KEEPING WELL AND MAINTAINING INDEPENDENCE

This section sets out our approach to empowering people to manage their lifestyles in ways that are beneficial to their health and enabling them to live independently in the community for as long as they are able and want to. It also describes our approach to enabling people to regain or maintain their independence when difficulties arise. It describes a sample of the current range of preventative services in the county, outlines the work being done to develop the evidence base for increasing investment in prevention, and summarises our current priorities for such investment.

Defining Prevention

Preventive services are those that:

- Prevent ill health across the whole population so that people are healthier for longer and
- Prevent or delay the need for more costly and intensive health and social care services

There are three different but complementary approaches:

- **Universal / Primary prevention**

  Primary prevention is aimed at people who have no particular social care needs or symptoms of illness. The focus is on encouraging and enabling the whole population to take responsibility for maintaining their health, independence and wellbeing. The intention is to prevent disease and ill health from occurring in the first place.

  Primary preventative services and interventions include everything from healthy eating advice, community exercise programmes and immunisations, through to the provision of sports facilities such as gyms and swimming pools, libraries, and adult learning. They also include initiatives to ensure that older people enjoy equal access to universal services and have access to good quality and timely information which will help them to maintain control of their lives and make informed choices.

- **Selective / Secondary prevention**

  Secondary prevention is more targeted and may be applied when disease first emerges or when individual needs increase, for example, after a bereavement. The aim of the approach is to intervene early to prevent further progression of disease, loss of independence or deterioration of personal wellbeing, and to support people to actively improve their situation.

  This approach includes expert patient and self care programmes for people with long term conditions. These provide patients with the information, advice and support they need to manage their overall health and condition.

  It also includes those that offer that ‘little bit of help’ such as shopping, gardening and befriending services.

- **Indicated / Tertiary prevention**

  Tertiary prevention is typically focused on people for whom adverse outcomes or problems have already occurred. The aim is to prevent reoccurrence or a worsening of the person's overall condition which could lead, for example, to that person needing to go into hospital or long term, residential care.

  The focus here is on maximizing a person's functioning and independence through rehabilitation / enablement services, or joint case management of people with complex needs or long term conditions.

Current Position in Oxfordshire

A wide range of services and interventions is already in place in Oxfordshire covering all three of these approaches, as outlined in Appendix 4. These include:

- **Falls prevention** - NHS Oxfordshire, Oxfordshire County Council and Oxfordshire Falls Services have worked together to reduce the incidence of falls in Care Homes. The number of medicine reviews in the community and in care homes has also been increased which reduces the number of falls.
- **Oxfordshire Exercise on Referral Scheme** – General Practitioners, NHS Oxfordshire, District Councils and exercise providers have developed a secondary prevention programme of prescriptive exercise to patients who have been identified as having existing disease and who could achieve measurable benefits from taking more exercise.
- **Cardio Vascular Disease Project** – this is a multi agency project, involving GP practices, workplaces and pharmacies that have screened people aged 40 to 74 to identify the risk factors associated with developing cardio vascular disease. People found to be 'at risk' are signposted to appropriate treatment and prevention services. The project is expected to inform the roll out of NHS Health Checks in Oxfordshire from 2011/12.

Some of these services and interventions fit into more than one category. For example, the Falls Service operates across all three stages, by:

- Providing information and advice through talks and leaflets on how to prevent falls to the general population (primary prevention)
- Undertaking falls assessments with people who have had a fall, and providing advice and guidance through balance and safety classes to reduce risk of that person falling again (secondary prevention)
- Providing advice, guidance and structured exercise programmes to people who have, for example, suffered a broken hip, to prevent further falls and serious injury, and help to restore confidence and mobility (tertiary prevention).

People in Oxfordshire are generally healthier compared to the national average. However, smoking, excessive alcohol intake, poor diets and

insufficient exercise mean that some people are at greater risk of ill health in older age. People living in areas of deprivation and minority population groups are more often at greater risk owing to poor lifestyles compounded by other socio-economic and environmental issues.

Local activity to support healthy ageing includes:

- Public health information programmes and awareness rising aim to **influence lifestyle choices across all population groups including older people**. Specific programmes such as Falls Awareness, 'Keep Warm, Keep Well' are more targeted at vulnerable older people.
- Appropriate training for professionals and volunteers working with older people and programmes or events provided in the community all support **individual behaviour change**. Examples are Health Walks, community exercise classes and training to support older people keep active and to eat healthily.
- Active Ageing Initiatives such as community exercise and dance programmes, adult learning, healthy lunch clubs, IT training for older people and the recent Adding Life to Years project have supported older people to **access appropriate information, remain mentally and physically active and socialise with peers**.
- The multi-agency Oxfordshire Sports Partnership have broadened their remit to include physical activity as well as sport and are taking a leading role managing GO Active (Getting Oxfordshire Active project) and the implementation of the 'Be Active, Be Healthy' national plan for getting the nation moving within Oxfordshire.
- Increasing adult participation in active recreation and sport is a Local Area Agreement target and all partner agencies in Oxfordshire are contributing towards this shared goal.

However, our preventive services do not yet meet the needs of older people as effectively as they might. Through the Joint Strategic Needs Assessment and specific needs assessments relating to the physical and mental health of older people, we have developed a good understanding of the needs of our ageing population. The gaps in service provision may not be geographical, although this is likely to be an issue for the delivery of some services. They may be gaps in coverage of specific social groups or age bands or in a particular level of prevention.

We need to do more work to understand how well the current range of preventative services and approaches addresses current and future needs, and how we can improve the effectiveness of all preventative services (a gap analysis). There is also a need for greater clarity about where investment in prevention is being made, by which organisations and to what end.

As part of our future strategy we intend to establish what range and configuration of preventative services will be most effective in improving the health of the older population, supporting people to live independently and reducing demand for intensive social and health care services.

Commissioning Priorities for 2010 - 2015:
Developing a strategic approach to prevention

Investing in services and approaches to prevention that ensure that people are healthier for longer and prevent or delay the need for intensive health and social care services will bring benefits for both individuals and the community. However we must ensure that any such investment is targeted and focused to best effect and that resulting efficiency savings are captured and diverted into those areas of support that are most effective. We will need to build a sound business case for preventative services in the county.

Our investment will aim to achieve the following outcomes:

- Improve the health of Oxfordshire's older population
- Increase the number and proportion of older people who are living independently in the community
- Reduce the number and proportion of older people who need intensive health and social care services

To achieve these outcomes we will need to:

- Increase the range and quality of preventative services and approaches that promote independence
- Recognise diversity and address the needs of Oxfordshire's diverse older population
- Prioritise investment where the evidence base is strongest
- Develop a framework for sharing investment and savings across health and social care budgets, and where appropriate, with district councils, voluntary sector organisations, private sector providers and others
- Achieve best value from our internal and contracted services
- Be prepared to change our approach to service delivery

In the future we will expect to see:

- An increase in the range and quality of services for people who are not eligible for social care services
- The development of targeting as an approach to the delivery of preventative services
- An overall shift in investment towards prevention and away from acute provision

To achieve these aims we will work together with older people to:

- Clarify and confirm our criteria and priorities for investment across all three stages of prevention
- Clarify and establish the 'evidence standards' that we will use to guide our investment in the primary, secondary and tertiary approaches to prevention
- Review and establish what systems, tools and processes are needed to enable us to:
    - Target our services towards the people and places where they are most needed, when they are needed, and to evaluate the impact of these services.

    - Monitor across the whole system the progress and impact of this shift in investment towards preventative and enabling services, and enable efficiency gains to be captured and factored into joint investment planning[15].
- Establish a baseline and performance management framework for our work in this area, including a range of targets and detailed objectives, to help us monitor progress towards the achievement of our goals
- Review our existing services to establish their contribution to the achievement of the outcomes above, and inform decisions regarding future investment, service redesign, and options for tendering and procurement
- Continue to develop the evidence base for prevention, and in particular, develop our knowledge and understanding of how we can effectively identify people who may be on a pathway towards dependency on intensive support , and turn them back
- Develop and put in place a plan to increase investment in preventative services, and improve the performance of existing preventative services and adapt or redesign these services where appropriate

Commissioning Priorities for 2010/11

While we are developing our longer term plans for services and approaches to prevention, we intend to give priority in the coming year to the following initiatives:

- **Information and access initiatives, including:**
    - Information targeted at all older people, through a range of media
    - Life planning courses for people as they age, e.g. 40+, 50+
    - Identifying and targeting specific information at specific groups of people, for example, self funders
    - No door the wrong door, single point of access – initiatives to join up services and help identify earlier older people who may need help
    - Signposting systems, such as 'Wayfinders' and village agents who can help older people to navigate the complexities of local service provision
    - Initiatives to increase carer awareness and self identification

- **Development of and extension of the current menu of wellbeing services, including:**
    - Initiatives that combat social isolation, such as befriending, lunch clubs
    - Inter-generational initiatives
    - Community safety advice and support, e.g. smoke alarms, advice on dealing with bogus callers, crime prevention
    - Advice and information on housing choices and improvements
    - Help with transport and getting out and about

[15] By October 2010 – Putting People First Milestone

- **Healthy living advice and support, such**:
  - Exercise classes
  - Development of continence awareness raising campaign
  - Weight management services and initiatives
  - Smoking cessation initiatives and services

- **Screening:**
  - All screening programmes
  - NHS Health Checks for 40-65 yr olds
  - Breast Screening
  - Bowel screening introduction for 60-69 year olds. New programme of investment from 2010

- **Obesity, exercise and weight management:**
  - Targeted exercise & lifestyle intervention
  - Weight management services and initiatives
  - Referral to weight management services by primary care. New service commissioned to treat morbidly obese patients from 2010

- **Early intervention**
  - Case finding initiatives and programme
  - Case co-ordination / service navigation services
  - Development, trial and evaluation of targeted, outcomes-based early intervention service, e.g. Turnaround

- **Support for carers**
  - Carers' respite services
  - Supporting carers to maintain and (re-) enter paid employment
  - Skills and capacity to identify and assess carers' needs, including in hospitals
  - Emergency carers support service
  - Training for carers of people with dementia

- **Help to live at home**
  - Initiatives to speed up implementation of major adaptations that would enable older people to remain in their own homes for longer
  - Managed pathway for those not eligible for social care
  - Practical help with shopping and minor repairs
  - Advice and information on housing choices and improvements
  - Crisis response / out of hours services
  - Joint, community based health and social care support for those with long term conditions and complex needs
  - Extra care housing; reablement; falls prevention; telecare – alert service and provision of low level equipment

- **Healthy living advice and support, such:**
  - Medicines Reviews
  - Smoking cessation initiatives and services
  - Falls prevention.

6. CARERS IN OXFORDSHIRE

In Oxfordshire many people of all ages make a tremendous commitment in order to care for family, friends, and neighbours who would not be able to live independently without their support. Carers provide the majority of care in the community and it is estimated that they save Oxfordshire **£661** million per annum (Carers UK, 2007). This section describes our approach to supporting these carers in their caring roles and to helping them in sustaining their own wellbeing, particularly as they themselves get older. It describes the current strategy and commissioning plans for supporting carers, identifies gaps in meeting their needs, and summarises our current priorities for further investment.

Defining Carers and Their Role

In Oxfordshire in 2001 there were a total of 53,455 unpaid carers, almost 9% of the population. It is anticipated that by 2029 this number will grow to 64,035. Just over half of all unpaid carers (52%) were between 25 and 54 years old and 22% were aged 55-64. Overall 1 in 4 carers devoted 20 hours per week or more to their caring role. Over 10,000 unpaid carers were 65 and over, and 29% of these provided fifty or more hours of unpaid care per week.

Almost two thirds of carers are of working age and represent 1 in 7 of the workforce. Carers often experience financial disadvantage and lose on average £9000 per annum in income when they become carers (Carers UK). 1 in 5 carers give up work to care, which means the economy loses a substantial part of the workforce annually. Among young adults aged 16-24, caring reduces the likelihood of participating in further or higher education, with an impact on future earnings and their own personal development. (ONS006)

Carers providing over 50 hours per week have been identified as being at the highest risk of disadvantage in terms of poor health, income, employment and education. Carers aged 65+ who are providing 50 hours week plus are particularly vulnerable to ill health. The majority have a health condition directly related to caring such as back problems, stress, anxiety and depression (Carers UK 2003 Missed Opportunities). Carers of working age who provide 35 hours or more a week care are considerably more likely to report being in poor health than other carers[16].

There are seven areas of rural Oxfordshire ranked in the top 10% nationally in terms of the number of people providing unpaid care. Over one fifth of Oxfordshire's population is living in areas ranked within England's most disadvantaged 10% regarding distance to services.

Current Position in Oxfordshire

Since the first National Carers Strategy 1999 and the introduction of the Carers Grant, now integrated into the Area Based Grant, there has been considerable progress nationally and locally in supporting carers. The new National Carers Strategy 2008-2018 represents a landmark government commitment to carers for provision of breaks through additional health funding

[16] CES Report 3 Carers UK University of Leeds 2007

and employment opportunities through funding to JobcentrePlus. It sets out five outcomes, so that carers will be:

- Respected as expert care partners and will have access to the integrated and personalised services
- Able to have a life of their own alongside their caring role
- Supported so they are not forced into financial hardship
- Supported to stay mentally and physically well and treated with dignity;
- And Children and young people will be protected from inappropriate caring

In 2009 a new Oxfordshire Carers Strategy 2009-12 was agreed following wide engagement and consultation. It integrates the vision of the new National Strategy and what carers and carer's organisations in Oxfordshire have told us they want and need. The County Council, the Primary Care Trust and partners have set out their own action plans to implement the key priorities for Oxfordshire. These will ensure we:

- Have a range of good quality and flexible services to provide breaks for Carers
- Identify, support and signpost Carers to good quality information and support
- Help maintain and safeguard the emotional and physical health and wellbeing of Carers and their families
- Help support Carers to have a life of their own through access to work (and financial security), education, training and leisure.
- Help ensure services and service developments are Carer led and where possible in line with what Carers say they want and need
- Provide equitable services that all Carers can access

Locally a full review of service provision was undertaken in 2009 benchmarking current services against our strategic objectives. The carers' grant is no longer ring fenced and is paid via the Area Based Grant which is subject to Oxfordshire County Council's procurement rules. The current contracts for Carers services expire in March 2010 and new contracts for Carers Services will be awarded through a process of competitive tendering. The main findings were that:

- Only 10% of carers are currently known, all partners need to identify, support and signpost those who remain 'hidden'
- A comprehensive model for consultation, information, involvement and participation of carers is needed.
- Improvements are needed in the quality, distribution and evaluation of information.
- There is some duplication of services; better targeting of special needs and improved value for money needs to be achieved.
- Not all services can be accessed equitably and services vary across the county.
- Provision of flexible breaks needs to be reshaped in light of Self Direct Care, and better data sharing is needed to ensure better targeting of resources.

- A strategic model is needed to support carers to have a life of their own which includes support to access/remain in employment, education, training, leisure and universal benefits advice.
- Work with GPs is needed on improving carers' health and wellbeing and investment in carer specific training is still needed.
- New outcome based frameworks are also needed to monitor and evaluate carers' services and to enable better commissioning on behalf of carers.

Currently local services are commissioned from early intervention when people commence their caring roles to intensive caring at the end of life. These are linked to the Oxfordshire Carers Strategy priorities and are informed by what Carers say they want and need. Carers are now directly involved as expert partners with commissioning and service development and review.

Free, direct access information, advocacy and services for carers are provided through Carer Support Services (Carers Centres) at any point in their caring career. Linked to these are a range of preventative services including carer support, training, wellbeing services and breaks, support for work, education and wider opportunities. For carers requiring more intensive support health, social care and other partners provide a range of specialist breaks and services, via direct payments and the developing personalisation agenda.

The vast majority of carers will never have contact with Adult Social Care, but if identified and signposted early to Carer Support, the likelihood of their caring successfully is greatly increased. Work aims to raise carer awareness for the general public, GPs and other professionals.

The approach is to transform how we support Carers in their caring roles.

- It recognises that healthy, fulfilling and sustainable caring often requires public awareness and early engagement: carer identification, timely information and signposting to responsive and good quality support.
- It prioritises support for carers own health and well being and the right to a life outside of caring, so carers can have active and fulfilling lives.
- It moves across the carer pathway from prevention and early intervention to intensive caring and end of life. While aiming to provide specialist or long term support for those who need it.
- It recognises that ageing carers are particularly vulnerable; community support is particularly valuable to enable them to have healthy and successful future years.

Commissioning Priorities for 2009 - 2012

The Carers Commissioning Plan 2009-2012 in Oxfordshire sets out a framework for the development and delivery of a broad range of services. It aims to meet the needs of a changing and ageing population and an expected increase in the numbers of carers. It seeks to reshape services to deliver against our direction of travel outlined in Ageing Successfully and to progress the national shift in focus towards prevention.

The Carers Commissioning Plan aims to support carers over the course of their caring career which may range from a few weeks to a lifetime of care. Investment in carers provides best value prevention, supporting the wellbeing of both carer and the person cared for and promoting independence. It is founded on carer choice and the development of personalised services. Carers are relevant to all service areas and all sections of the Ageing Successfully strategy.

Partnership working is essential to carer identification, delivery of support for carers and a move towards a more inclusive society. Caring is no longer an issue for social care alone but for the whole community, employers, and universal services. The application of the Social Model of Disability, supported by the Carers (Equal Opportunities) Act 2004 and the current Equalities Bill helps to ensure Carers are entitled to the same opportunities as the rest of the community, in employment, and in their wider aspirations.

The commissioning plan proposes that the number of projects is rationalised and reshaped in light of new direction of travel and pressures. To ensure equality of access to uniform services it is proposed that the county has one contract for a countywide carers support service, which will provide support to carers including difficult to reach groups such as Black and Ethnic Minority groups. This will mean a generic carers' support service with universal coverage, less specialist projects and simplification of access to support for carers.

It is also proposed that there is a simplification of contractual arrangements, which will translate into a reduction in resources spent on monitoring for both providers and commissioners, and that an outcomes framework is introduced to support better evaluation of services and commissioning.

The Carers' Commissioning Plan 2010-2013 sets out the changes required in commissioning to meet the new priorities and demographic challenges in relation to service provision. A summary of these include:

- Targeted information and advice to support carers
- An increase in investment in carers' breaks to encompass increased use of direct payments and 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
- Taking forward the strategic partnership which is currently working on a pathway to 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.

Equalities

The Equalities Bill 2010 may have far reaching effects as it will make illegal discrimination against carers on the grounds of association with someone with a disability in employment and in the provision of goods and services. It would support carers to use the same services, resources and facilities as people in the wider community and require that barriers to social inclusion be addressed.

7. REHABILITATION AND RECOVERY

The importance of rehabilitation to support people to get to their maximum level of functioning is increasingly recognised within both health and social care. Significant investments have been made recently in Oxfordshire to deliver community based rehabilitation services. However it is also acknowledged that there is a need to review the existing services to ensure that their delivery is both effective and efficient.

This section sets out our approach to future development, enabling more people to regain or maintain their independence when difficulties arise. It describes a sample of the current range of rehabilitation services in the county, outlines the work being done to increase our investment and summarises our current priorities for such investment.

Defining Rehabilitation and Recovery

This is the period when individuals undertake a comprehensive programme to reduce or overcome the deficits caused by an accident, illness or operation. It is to assist the individual to re-gain the optimal mental and physical abilities which have been damaged.

Rehabilitation is carried out in a number of settings including hospital and at home. The location is defined by the individual's medical and social requirements. It can be long term care and support to all activities or a short programme to enable individuals to regain their former level of independence.

Current Position in Oxfordshire

In recent years there has been a clear shift in resources towards supporting rehabilitation work, including use of new technology in care homes, development of intermediate care services outside of hospital settings and the introduction of first response team to work alongside the intermediate care services. Other examples of improvement include the following:

- Pulmonary rehabilitation in place across the county and expanding
- Increased investment in physiotherapy across the county
- Investment in community rehabilitation to support early hospital discharge
- Development of community rehabilitation and recovery for stroke survivors
- Piloting of early supported discharge in Oxford City for stroke rehabilitation
- Return to work service for people of working age following a stroke

This has led to a range of benefits in terms of the outcomes for older people and delivery of services, including:

- Reduction in levels of personal support required at home
- Reduction in admissions to care homes
- Shorter lengths of stay in hospitals
- Moving of resources to follow individuals
- Improved quality of life

Commissioning Priorities for 2010- 2015:
Change from current to future state

Interventions that support people to maximise their function and recover faster from illness are essential to any system. They support timely discharge from hospital and prevent premature admission to long term residential care. They form part of the continuum spanning acute and long term care, and must be delivered by integrated health and social care approaches and teams.

In developing our services for the future, we intend to adopt the following principles:

- Commission for individual outcomes not activities
- Have individual recovery plans that include physical, social and psychological elements, involve carers and which emphasise self care, autonomy, independence and social connection
- Have enabling environments in care homes
- Move from task based payments for domiciliary home care to outcome based payment
- Fully utilise the skills of physiotherapists and occupational therapists across the county
- Develop initiatives such as learning to cook for older people to support recovery
- Take away a mind set of 'if I get better my care will be taken away'
- Promote access to gentle exercise programmes in the community to continue recovery when formal input ends – e.g. Green Gyms.

This will enable us to move from the present position to a better future state as described below:

Current state	Future state
Intermediate care delivered by health and social care integrated teams	All rehabilitation and recovery delivered by integrated approach across organisation boundaries
	Personalised care planning and integrated assessments with joined up multidisciplinary working along care pathways
Domiciliary personal care paid by tasks	Payment by outcomes achieved
Services commissioned by activity	Services commissioned by improved outcomes
Entering a care home is where I will stay until I die	Individuals can improve with the care given in a care home and be enabled

	to live independently again
Lack of facilities for older people to continue or take up exercise that is right for them	Easy local access to exercise to maintain or improve function
'Done to' care planning	Personal co-production care planning that takes in all aspects of life to maximise function and independence

Commissioning Priorities for 2010/11

The key priorities for commissioning in the coming year are as follows:

- **A Review of intermediate care** to create a more effective system between the NHS Oxfordshire and Social and Community Services in line with the Department of Health's "Intermediate care, a halfway house" guidelines published July 2009.
- **Information and advice** will be enhanced through the creation of access points offering prompt information and advice and services to people at the first point of contact.
- **Healthy Workplaces** a project to support people to stay economically active and encourage paid work beyond the traditional retirement age.
- **Older people's exercise:** NHS Oxfordshire and Social and Community Services will jointly commission an Oxfordshire wide older people exercise, health and wellbeing service. This will develop greater choice and increased access to appropriate, evidence-based exercise and health and wellbeing advice for older people across Oxfordshire.
- **Personal budgets**: NHS Oxfordshire is one of the 20 fully evaluated national sites participate in the national pilot of personal health budgets in continuing health care.
- **Implementing the stroke care pathway** will see the development of physical and psychological rehabilitation and recovery in the community to improve the quality of care for individuals. This will ensure effective use of resources, reducing length of stay and excess bed days.
- **Fractured neck of femur integrated care pathway** will be developed alongside the fracture prevention services of the osteoporosis and falls service and in line with Department of Health Guidance 2009. This will support the continued reduction of serious fractures in the older population and the early discharge following a fractured hip to patient's home or community setting for rehabilitation, reducing length of stay and excess bed days.
- **Implementation of the dementia and older people's mental health strategy** will continue to implement the National Dementia Strategy locally and integrate the developments with an older people's mental health strategy.
- **A service model for continence services** will result in a contract for provision of an integrated continence service across the county which focuses on rehabilitation.

The anticipated benefits of this approach are:

- There will continue to be a year on year reduction in the number of patients who have fractures associated with a fall aged over 65 years.
- There will be fewer people over 65 having a stroke and the overall quality of life for those who do have a stroke will be improved compared to 2008/09.
- Increased access to structured exercise and health and wellbeing education sessions
- There will be fewer people over the age of 65 suffering from incontinence and the quality of life for those with continence problems will have been approved. An integrated rehabilitation focused continence service for adults across the county will ensure appropriate support is in place
- People who suffer a fractured neck of femur (hip) will be supported by an integrated pathway.

8. LONGER TERM AND ONGOING SUPPORT

This section of the strategy sets out our approach to the ongoing support that a small number of people will require due to the impact of a Long Term Condition or frailty resulting from old age. It reviews the current arrangements in Oxfordshire, sets out how we plan to shift the emphasis more towards self care and outlines our commissioning intentions for future years.

Self care was highlighted in the NHS Plan (Department of Health 2000) and more latterly in 'Your NHS Your Future' as one of the key building blocks for a person-centred health service. Research shows that supporting self care can improve health outcomes and increase the satisfaction of people who use services. Supporting people to self care represents an opportunity and challenge for health and social care to empower people to take more control over their lives. However it will require a significant change in the attitudes, behaviours and skill base of those working in health and social care to make personalised services, enablement and early intervention a reality.

Defining Long Term Care

Long term care involves a variety of services that meet the needs of people who cannot care for themselves for long periods of time due to chronic illness or a disability. It includes assistance such as dressing and bathing and going to the bathroom. Increasingly, long term care involves providing a level of nursing and therapy that requires the expertise of skilled practitioners to address the often multiple chronic conditions associated with older populations. Often it includes medical care delivered within the locally agreed shared care protocol. Long-term care can be provided at home, in the community, in an assisted living setting e.g. (Extra Care Housing), or in a care home.

Current Position in Oxfordshire

Home support provision in the county is currently under supplied. The cost, which ranges from £16 to £30 per hour, is high in comparison to comparator authorities.

A broad range of other day services commissioned by Oxfordshire County Council is being delivered by many different organisations e.g. private, voluntary, District and Parish Councils, adult social care internal and external provision. The cost of these services ranges from £6 to £41 per session, which again is high in comparison to comparator authorities. There is a lack of data on the levels of home based services purchased and arranged by self funders in Oxfordshire. National estimates suggest that 50% of home support capacity could be purchased by self funders.

Additional services are available which promote independence and support the prevention agenda. These range from carers' services, telecare, equipment, advice and information services. However the provision of such services is currently measured against output based criteria. More evidence based research is required to assess the impact of some of these services in terms of achieved outcomes.

There have been a number of recent developments in the extension of health care services outside hospital settings. For example, during 2009/10 we have increased capacity in physiotherapy and each GP can now offer access to the service; in the winter of 2009-10 we started a new pilot tier-2 musculoskeletal triage and treatment service operated by the Nuffield Orthopaedic Centre and diabetes services have also been developed. However there is still a lack of supply of health care outside of hospital to support older people closer to home. As a result the majority of health care for older people is still delivered within the acute care setting; 80% of acute care for the over 65+ population occurs within the Oxford Radcliffe Hospital Trust.

There is a high demand on care home placements due to limited supply of alternative options that can enable people to make different choices e.g. Extra Care housing. Social care purchase approximately 44% of the care home market, with the rest purchased by self payers. The present costs of care home placements in Oxfordshire range from £375.00 to £637.00 or more per week.

Currently very few self funders in Oxfordshire access the social care assessment service, yet they make up over half of residents in care homes. There is evidence to suggest that self funders move into care homes with lower levels of need than those helped by the Local Authority. Self funders present themselves to social care once their finances have depleted below £22,000, often having bought comparatively expensive placements.

Overall the current commissioning and supply of long term care in the county is concentrated on outputs and volumes rather than patient/user agreed outcomes. It is configured around tasks and the time required carrying out the tasks. There is limited emphasis on and no incentives to the market to deliver approaches that support self care and management.

It will require a significant shift in purchasing arrangements for an organisation to move to outcomes based commissioning covering a range of tasks required by an individual which may span different services. Many outcomes desired by older people may also fall outside the remit of social care, for example, continuing to participate in social networks, better transport, improved health and mental well being. The model for existing home care, residential and nursing care, day services and other services will need to be redefined accordingly.

Commissioning Intentions 2011-2015

Our future intentions for commissioning are summarised below. Detailed plans to deliver these will be developed in 2010/11.

- Incentives to stimulate the supply market to reduce the cost of home support and improve the standards of registered care in particular dignity, choice and control of service users, and the skills and training of the workforce.
- Continue to move to consumers buying their own care and reduce block contracts. Support existing suppliers to develop and deliver effective marketing strategies
- Ensure that people suffering the impact of stroke are able to have extended periods of rehabilitation
- Develop a detailed day services strategy that will fit the choice agenda, shift the suppliers to deliver appropriate services, outline future commissioning and decommissioning intentions.
- Explore the feasibility of establishing a nurse led Hospital at Home service in Oxfordshire to facilitate effective and safe early discharge of patients with Long Term Conditions.
- As part of the development and implementation of proposals being explored within the Creating a Healthy Oxfordshire programme, plans will be developed to assess the benefits of developing locality based multi disciplinary community teams to provide a range of well co-ordinated preventative and post –discharge care to patients with Long Term Conditions.
- Specify an alternative service model for utilisation of care home beds to deliver crisis and emotional rehabilitation support with clear goals and aims to enable people to return home
- Forge partnerships with stakeholders to ensure that people in care homes have access to real opportunities to maintain their social networks and activities of choice outside of care homes.
- Undertake analysis and evaluate the effectiveness of the Access Enablement Services.

Commissioning Priorities for 2010/11

Outlined below are our specific priorities for commissioning in the coming year:

- **Home care:** Specify and commission outcome focused home support and evaluate the effectiveness of outcome focused home support pilots that are in place for Stroke and dementia; develop plans for future reshaping of services.
- **Home Care**: Working closely with the Transformation team, support and complete the development of the Resource Allocation Policy.

- **Provider Management**: Ensure that all supply of registered care services maintain and improve their star ratings.
- **Self care project:** a project will be scoped and tested to increase the ability of clinicians to help patients with Long Term Conditions to help themselves; increase the skills of all people with a Long Term Condition to actively manage their condition and be as independent as possible; and introduce personalised care plans for all people with Long Term Conditions
- **Telecare:** Stabilise and develop the newly awarded contracts for telecare and ensure that there is a cultural shift where this is considered as a real option to enable people to continue living at home; implement plans for a telehealth pilot for people with Long Term Conditions
- **Musculoskeletal Service:** Build on the successfully delivered pilot for tier 2 musculoskeletal triage and treatment service and deliver a sustainable community based triage from 2011 onwards
- **Diabetes:** Provide structured education and podiatry particularly for Black and Minority Ethnic communities suffering from Diabetes
- **Community respiratory service:** Review the pathway for the provision of community respiratory services, in line with new national guidelines.
- **Chronic Kidney Disease:** Review the potential to reduce hospital admissions resulting from Chronic Kidney Disease, which is associated with vascular conditions.
- **Case Management:** Develop plans to increase the effectiveness of the case management service, to support further reductions in the number of avoidable admissions.
- **Hospital at Home:** A feasibility study will be undertaken to establish whether a nurse led Hospital at Home service in Oxfordshire to facilitate effective and safe early discharge of patients with Long Term Conditions is possible.
- **Virtual Ward:** Proposals being explored within the Creating a Healthy Oxfordshire programme include an assessment of the benefits of developing locality based multi disciplinary community teams to provide a range of well co-ordinated preventative and post–discharge care to patients with Long Term Conditions will be tested. This will reduce admissions for general medicine, gerontology and Chronic Obstructive Pulmonary Disorder.

Benefits

As a result of pursuing these plans we expect to realise the following benefits:

- People receiving case management will have their quality of life assessed to detect changes in their mobility, pain, ability to perform activities of daily living and whether they are feeling depressed or anxious and services will then be provided accordingly.
- More people with a Long Term Condition will have a named Lead Professional to help them develop a personalised care plan to manage their condition as part of the self care project.
- More people with a Long Term Condition will be either discharged from hospital earlier or prevented from having to go to hospital by using

telemedicine to enable them to live independently. (This is part of a wider project being led and funded by Oxfordshire County Council and involving Community Health Oxfordshire to develop innovative ways to make services more productive)

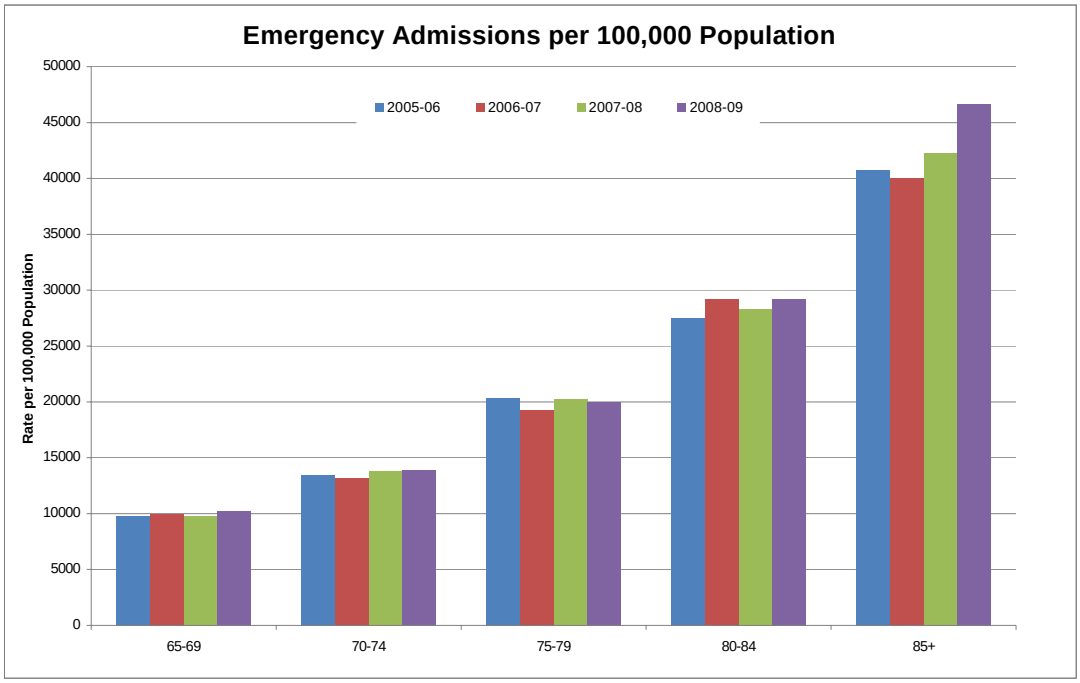
- More people will benefit from community based physiotherapy for problems with their joints or spine to reduce their pain and improve their ability to move.
- More people requiring treatment for problems with their joints or back will be able to access this in community locations
- More people, who have recently been diagnosed with type 2 diabetes, will receive structured education so they know how to reduce their risk of suffering from complications.
- More people with a very high risk of developing a Long Term Conditions will be identified earlier and given support to reduce risk through increased screening for vascular conditions. This includes people with diabetes which will mean they can access support earlier and so reduce their risk of developing complications more effectively. (This is a benefit of the NHS Health Checks project, part of the Staying Healthy initiative)
- People with diabetes who are admitted to hospital for any reason will spend less time in hospital. This will be because of improvements in services which will mean they are less likely to experience complications.
- More people will benefit from community based pulmonary rehabilitation including those with moderate Chronic Obstructive Pulmonary Disease. They will learn how to exercise and manage their respiratory condition, so they retain their independence as much as possible and are able to walk further.
- More people will be discharged from hospital earlier because they will be able to receive their care at home.
- People with complex health care needs will have their records at home stored in a yellow folder so all health and social care professionals know where to find them, and so are better able to co-ordinate their care. This is particularly important when the person's condition deteriorates and they are visited by a paramedic or out of hour's doctor.
- Older people living in care homes who have unmet oral health needs will receive more help

9. HOSPITAL CARE

The focus on keeping people well (prevention) seeks a shift in investment away from acute hospital care to community services. This section sets out our future approach to the provision of Acute and Community Hospital care for older people, including outpatient services, elective / planned care and emergency and unplanned care. It outlines the current position and sets out our priorities for future commissioning and service development.

Current Position in Oxfordshire

In the UK as a whole people over 65 use three and a half times the amount of hospital care of those aged under 65, and almost two thirds of general and acute hospital beds and occupied by those over 65. This pattern is mirrored in Oxfordshire. The incidence of emergency admissions to hospital amongst older people in the county is illustrated in the chart below.



The majority of local people, over 90%, are seen and treated in the county's four acute hospitals - the John Radcliffe, Churchill, and Horton Hospitals that comprise the Oxford Radcliffe Hospitals Trust and the Nuffield Orthopaedic Centre - and by Oxfordshire and Buckinghamshire Mental Health Foundation Trust. In the south-east of the county people also access the Royal Berkshire Hospital in Reading and in the south–west the Great Western Hospital in Swindon. The opening up of choice in where people receive hospital care in the last few years has not made a significant difference to the pattern of planned and emergency care.

NHS Oxfordshire, the Oxford Radcliffe Hospitals NHS Trust and the Nuffield Orthopaedic Centre have been working together on care pathways to ensure that local hospitals have the capacity to offer responsive and high quality urgent and acute care for the older population.

With regard to planned care, the Oxford Radcliffe Hospitals are currently experiencing significant difficulties in ensuring patients do not wait longer than 18 weeks between referral by their GP and the start of any required consultant led treatment. Further work is required to review both the scale of the problem and how this target can be delivered in a long term and sustainable way. A clear agreement will be needed as to where the costs of bringing this performance back on track are to be borne.

NHS Oxfordshire and the County Council's social and community services have also developed services outside of hospital in the community and

primary care. This has been undertaken in Stroke care and will be repeated in other pathways of care such as fragile fractures. To expand these services further commissioners will need to release more resources from existing services and move them to follow the patient.

Commissioning Intentions 2010-2015

Secondary care services are working together to ensure that areas such as maximising internal efficiencies through sharing good practice, avoiding duplication within Oxfordshire, working with other acute services to drive efficiencies and shifting services out of the acute sector are taken forward. The following areas are being progressed:

- Single point of referral into secondary care
- Reviewing clinical pathways
- Maximising estate utilisation
- Organisational Productivity

Improvements in primary care can also make a substantial contribution to delivering higher quality health care outcomes, while reducing costs. For example, Many older patients could be supported at home rather than undergoing acute medical admission to hospital if acceptable risk management and clinical monitoring could be achieved, However this will require a revolution in working patterns and in skill utilisation across the primary health care team, improvements in information systems and involvement of other healthcare workers who have not traditionally offered community based services.

In commissioning services for the future we will adopt the following key principles:

- Services will be developed in primary and community settings to reduce inappropriate emergency admissions to hospital
- The length of stay people experience in hospital will be limited to their physical and mental health needs for the level of care delivered
- Resources will be unlocked from acute hospitals and moved to support an increase of rehabilitation and care in the community
- Commissioners and clinicians will develop pathways of care to deliver excellent, evidence based care that meets national targets and standards and work towards all specialities achieving performance in the top quartile nationally
- Choice of where people can receive planned care from hospital will be supported
- Focus will be on early diagnosis and intervention

The outcomes we expect to achieve include:

- Reduction in emergency admissions
- Reduction in length of stay
- Move of rehabilitation in to the community
- Improved standards' of care

This will move us on locally as follows:

Current state	Future state
Rehabilitation in acute hospitals	In reach of community teams and step down pathways
High levels of admissions for conditions that can be treated in the community	To develop community based responsive care
Leaving hospital can feel like stepping off the edge of a cliff	Having post discharge support, settling in and proactive phone contact

Commissioning Intentions for 2010/11

Our priorities for development in the coming year are set out below.

Choose Well:
We will roll out the Choose Well campaign as an ongoing part of our patient education programme.

Single Point of Contact:
Following completion of a feasibility study we will pilot a single point of contact scheme, even if the proposed national pilot does not get launched within the year, but will ensure that it is able to adapt to any subsequent national scheme.

Phone first:
We will undertake a feasibility study to assess the potential to schedule more urgent care. This will involve the public telephoning relevant urgent care facilities

Direct Access Diagnostics:
Approval will be sought to conduct a feasibility study to determine if providing direct GP access to a range of diagnostic procedures will deliver cost savings to the NHS without reducing service quality or outcomes for patients

Delayed Transfer of Care:
We will aim to reduce delays significantly and eradicate this as an issue facing the local health economy by:

- Avoiding unnecessary hospital admissions
- Ensuring that a patient stay in hospital is limited to as short a period as possible so that they maximise the chance of maintaining their independence following discharge
- Making better use of transitional beds in a community or care home setting whilst the right long term solution is put in place for the patient, and exploring the feasibility of expanding this kind of care
- Working together across the system to ensure all partners improve discharge pathways and secure best value for money across the Oxfordshire health and social care economy.

Early supported discharge:
If a patient enters care as a result of an urgent care need (e.g. a fall), we will develop discharge planning processes to enable patients to return to their usual residence as speedily as is appropriate.

18 week waits:
The Oxford Radcliffe Hospitals are currently experiencing significant difficulties in ensuring patients do not wait longer than 18 weeks between referral by their GP and the start of any required consultant led treatment. Further work is required to review both the scale of the problem and how this target can be delivered in a long term and sustainable way. A clear agreement is needed as to where the costs of bringing this performance back on track are to be borne.

Cancer Services:
To achieve improvement in this area we will prioritise:

- A programme of patient and GP education and development of referral practice to improve compliance with the 2 week wait target for suspected cancer.
- Further work on screening and improving access to diagnostic procedures and treatment, for example through improved adherence to the two week wait for breast symptoms and the commissioning of increased radiotherapy fractions
- Enhanced GP, Out of Hours and Patient education to improve management of patients undergoing chemotherapy and ensure that chemotherapy patients who become unwell as a result of their treatment get the best and most appropriate care we will:
- Support for telephone triage and access to oncologists and development of oncology support in A&E to prevent inappropriate admissions to general medical beds and ensure appropriate ongoing treatment is provided to patients.
- A review of the need for additional clinics and an increase theatre capacity to manage the increase in demand and complexity of treatments.
- Development of a Local Awareness and Early Diagnosis Initiative**,** based on the National Awareness and Early Diagnosis Initiative (NAEDI) which aims to address poor public awareness of cancer symptoms, late diagnosis and delays in primary care.

Cardiac services:
We will make a number of improvements to cardiac services that will deliver improved quality of care for patients and reduce long term system costs. This links across a number of other initiatives, looking at all cardiovascular conditions in primary, secondary and tertiary care. We will:

- Review the quality of cardiothoracic Services against national standards and support any changes required. This is a deferred action from the 2009/10 Operational Plan.
- Review the effectiveness of Cardiac Rehabilitation services for secondary prevention of heart attacks to ensure we commission the most effective model of care.

Neurological conditions:
In order to implement the National Service Framework for Long Term (Neurological) Conditions we need to work across all providers, NHS, Oxfordshire County Council, charities, voluntary agencies, patients and carers, on a series of projects to develop services in the community to support independence for patients and carers and reduce avoidable admissions to hospital. We will prioritise:

- A neurological conditions information project to improve access to information for patients, GPs and service providers in order to improve diagnosis and ensure appropriate access to services and best use of all providers.
- Improved diagnosis of and reduced variation in treatment for people with Chronic Fatigue Syndrome
- A review of the pathway and services for patients with late stage Huntington's disease

Acquired Brain Injury service improvement:
To improve services for these patients we will undertake a feasibility study into the cost effectiveness of developing in county provision for patients with acquired brain injury

Repatriation of specialist services:
We will relocate certain specialist provision from outside Thames Valley into Thames Valley based hospitals in order to provide care closer to home, improve integration with non specialist services and reduce more expensive out of county referrals that are currently going to London and other locations.

Improve specialist home based care:
We will develop specific patient related services by working with Specialist Commissioning Group to assess services provided at home to support the long term needs of specialist patients (e.g. tube feeding and home Intra Venous for antibiotics), in order to reduce costs and improve quality.

By pursuing these initiatives we expect to achieve the following benefits:

- There will be minimal delays in accessing services
- After every urgent care event people will be given comprehensive information on how to manage their injury / illness at home.
- Diversion of patients from one hospital to another will be reduced; people will receive care in the closest hospital that best meets their needs.
- Ambulances will reach those people who most need them in an emergency in a timelier manner.
- There will be significantly reduced waits for in and out of hour's urgent care.
- More care and advice will be available from local pharmacies.
- People will be able to get prompt advice by telephone or the NHS Oxfordshire Web site.
- People will experience less delay for assessment, diagnosis and treatment.
- Patients will only be referred when necessary and to settings most appropriate for their needs.

- Patients will experience more evidence based, efficient and effective care.
- Average patient journeys will be in line with national waiting time targets.
- People at risk of developing cancer will be identified earlier through targeted screening and improved access to diagnostic procedures.
- Oxfordshire patients will be offered the full range of screening services as indicated by national guidance.
- Patients receiving chemotherapy will be well supported through their treatment.
- Improvements in awareness and early diagnosis will improve outcomes for patients.
- The quality and appropriateness of cardiac services (rehabilitation and cardiothoracic) will be evaluated.
- People with Neurological Conditions will have access to improved information about their condition and services available, including a directory of services and signposting for service providers, to support their independence and access to services.
- Access to specialist neurological diagnosis and advice will be improved.
- Pathways of care will be clarified, supporting more effective use of resources and independence for people with neurological conditions.
- Assessing services for patients receiving home care (Nutrition and Intra Venous antibiotics) will support more effective commissioning.
- The feasibility of offering services for patients with Acquired Brain Injury and adults with complex and continuing care needs within Oxfordshire will be clarified.

10. END OF LIFE CARE

This section sets out the current position with end of life care in Oxfordshire, outlines our approach to future development and highlights our priorities for investment in the coming year.

Defining End of Life Care

End of life care involves support to all those with advanced, progressive incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patients and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support. The time period involved will vary significantly depending on the individual circumstances of the person concerned.

Current Position in Oxfordshire

Evidence nationally indicates that around 70% of people would prefer the opportunity to die in familiar surroundings in the company of people they know. Currently in Oxfordshire however 56% of expected deaths take place in hospital amounting to an average of 2,500 deaths annually. There are 400

admissions a year of people who die within 48 hours of admission. Around 60 of these will come from Nursing Homes. There are also nearly 1,000 episodes of care per year relating to people in the last year of life who go into hospital as an emergency admission and are discharged within two days. For some patients this will mean only one admission but for many others this indicates a pattern of repeat emergency admissions. There have been a number of recent local developments aimed at reducing the dependence on hospital services in end of life care. These include:

- An increase in the number of pharmacies providing an enhanced service for End of Life Care patients
- Additional investment in night nursing services from Marie Curie
- Two six month pilots offering rapid response care to support patients and identify issues which need to be resolved to make the service developments functional
- A tender for a rapid response service to start in April 2010 offering care at home for a short period of time to:
    - Enable supported death at home
    - Manage any crisis in the last year of life which would normally lead to an acute admission
    - Provide symptom control intervention where necessary
- An education fund is being set up to provide funding for staff across health organisations including nursing homes, hospitals and community services.
- New staff roles being implemented to support improvements in care at the end of life across nursing homes, community and primary care.

These initiatives appear to be achieving significant improvements in end of life care. There has been an increase in the number of patients and carers supported by the pilot Rapid Response service at home and an Increase in the number of Care Homes engaging in the Gold Standards Framework for End of Life Care. There has been a reduction in the rate of emergency admissions within 48 hrs of death.

Commissioning Intentions 2010 - 2015

The basic principle behind our End of Life Care Strategy is that people in the last year of life should be:

- Cared for in such a way as to avoid emergency admissions to hospital as these are traumatic for individuals and families and do not follow the preferred model for palliative care
- Supported in their normal place of residence until the end of their lives whether that is their own home or a nursing or residential placement.
- Cared for by staff educated and trained in End of Life Care issues which equip them to be effective in the areas of pain and other symptom management, communication skills and emotional support.

The intention is to move the position on as follows:

Current state	Future state
Pain relief being delivered in the community is not a organised or universal service	Timely and effective pain relief delivered across the community
Lack of rapid response for rapid changes at EOL	Support at home to meeting urgently needs
Education for EOLC not universal	Education training and skill development across the whole health and social care workforce
Well established services for cancer suffers but not for all care groups	Equitable services regardless of diagnosis
Disjointed care due to lack of joined up services and communication regarding individuals	One data base and communication for people at end of life

Commissioning Intentions 2010/11

During 2010/11 we will build on the achievements we have delivered to date by delivering the outstanding changes to the revised care pathway which has been agreed between the various interested parties.

Improving access to end of life care services:
We will:

- Put in place new ways of working that will enable better identification of people who are within a year of death; in order that they can be offered the services they need in the most appropriate settings
- Ensure that patients within vulnerable communities and those with specific cultural needs, can access end of life services that are appropriate for them.

Development of end of life planned care:
We will extend the access to specialist planned care for people with Long Term Conditions whose end of life care needs can be anticipated, so that services for these patients are equitably provided across the county, which is not currently the case

Befriending services:
We intend to set up a service to support vulnerable people at the end of life to reduce unnecessary hospital admissions.

Rapid response service for urgent end of life care:
The tendering process for a new countywide rapid response end of life service will be completed. We expect this service to go live from April 2010 and to include short term hospice at home services as an emergency provision, until core community services can step in and take over.

Bereavement services:
We will increase investment into bereavement services in areas of deprivation in order to help the bereaved carry on without extensive support from primary and Mental Health care services.

In implementing these initiatives we expect to achieve the following benefits:

- Patients and carers will be able to input into the design of new palliative care services.
- Patients with a terminal illness and their families will be fully supported during their last weeks by a range of providers who will deliver appropriate care that has been informed by the patient's own wishes.
- Services will be developed within the community to provide both planned and unplanned care for patients at the end of their lives and will include new access to:
    - hospice type services in the patient's place of residence
    - additional capacity within community services to allow for a rapid response to unplanned need
    - sitting services to allow carers to have rest from caring duties in order to maintain their own health and wellbeing and ultimately their ability to cope
    - befriending services to ensure patients are supported during this difficult time
- All patients identified as needing end of life care will have the support of a key worker within the primary/community healthcare team that is supporting them, and this key worker will ensure that preferred place of care and death has been identified by the patient, and that all involved are aware of this.

11. DELIVERING OUR STRATEGY

Existing Expenditure Patterns

In 2008/2009 expenditure on Health and Social Care for older people in Oxfordshire amounted to a combined total of more than £286 million, of which £106 million came from the pooled budget between the County Council and NHS Oxfordshire (£83.5 M social care and £22.5 health). This sum excludes public health spending and some primary care costs which are not collected by age stratification. Sizable health expenditure on hospital and community services for older people is also excluded.

Appendix 5 provides an outline of anticipated expenditure in 2009/10. Over recent years spending patterns have seen a marginal shift towards prevention and offering real choices for people to receive care closer to home.

Future Use of Resources

Delivering our vision for the future will require complex changes which must be co-ordinated across the whole system. They will require further work on understanding local needs and reshaping the market of providers to refocus on more effective and best-value care and support arrangements. Assessing the type and quantity of services required well in advance of investment decisions will be crucial.

Our strategy requires a shift in investment from acute hospital services to early intervention and health promotion and the development of alternative

supported living arrangements for older people. The challenge is explicit in 'NHS 2010-2015'[17] which states this change will only be delivered through hospital-based care being re-structured. It expects the NHS to draw on the 'creativity and ingenuity of its staff to redirect resources across the system' and to 'divert resources further upstream'.

To achieve this shift in investment and to make best use of resources, Oxfordshire County Council and NHS Oxfordshire along with partners will:

- Invest in prevention to improve health outcomes and lessen future demand and support the voluntary and community sector to stimulate more preventative activities;
- Establish an integrated commissioning team across NHS Oxfordshire and Social and Community Services to deliver the Ageing Successfully programme;
- Promote innovation in service re-design and the use of technology through integrating the commissioning functions of the Oxfordshire and Social and Community Services in 2010/11 building on the success of section 75 pooled budgets;
- Reduce future demand for care in acute hospital settings and decommission services appropriately;
- Increase efficiency across all sectors to ensure resources are well spent;
- Maintain the active participation of service users and carers to ensure resources are used to best effect.

It is essential that there is agreement about the level of investment that will shift across the whole system to achieve the reform we are seeking and about the provision of transitional funding during a period of change when new services are being developed prior to existing ones being decommissioned.

To deliver the aspirations of this radical strategy and meet the pressures of future demographic change, there will also need to be agreement that the existing pooled budget arrangements will be significantly extended. The success of the strategy is predicated on the assumption that a much wider and broader range of funding streams will be part of future arrangements. This will be necessary to maximise the best use of resources across the partnerships between local government, health and the independent sector. Each proposed delivery project will also need to be carefully planned and jointly approved based on a robust business case with a clear financial plan which identifies its implications for the local health and social care economy as a whole.

Governance Arrangements

It is crucial that 'Ageing Successfully' has a high profile across the community and local agencies and that there is a corporate overview of Ageing Successfully across the County Council and NHS Oxfordshire.
The Health & Well Being Partnership Board (September 2009) has agreed to establish a Policy Board consisting of senior representatives of partner

[17] NHS 2010-2015: from good to great: preventative, people-centred, productive.' Department of Health 2009

organisations and other members to oversee the delivery of this strategy and the governance arrangements for integrated commissioning. The Policy Board will:

- Be accountable to all partner organisations.
- Provide strategic direction; agree priorities, outcomes and resources to deliver project objectives.
- Ensure time is allowed for Policy Board members to consult within their own organisation and with other key stakeholders on proposals to change commissioning policies, commit resources and/or enter into new contractual arrangements.
- Report to the Health &Well Being Partnership Board.

The Health &Well Being Partnership Board will review and monitor the delivery of this strategy and will report to the Public Service Board. Ultimately, accountability will lie with the NHS Oxfordshire Board and County Council's Cabinet. Day to day responsibility for steering integrated commissioning and endorsing proposals will rest jointly with NHS Oxfordshire's Director of Commissioning and Service Redesign and the County Council's Director for Social and Community Services.

The 'Ageing Successfully' Task Group will drive the development of the strategy and delivery plans. From April 2010 the emphasis will be on:

- Confirmation of the Task Group membership to ensure a partnership and inclusive approach.
- Preparation of detailed action plans, setting out lead responsibilities, timescales, reporting mechanisms and links with other strategies, including the Local Area Agreement.
- Robust costing of new project proposals and quantifying savings opportunities.
- Routine reporting to the Health &Well Being Partnership Board's Policy Board.

Information Support

A number of studies have identified incompatible electronic systems as a barrier to an integrated approach to commissioning services. The Care Quality Commission in its report 'The State of Health and Social Care in England' (February 2010) found that while partners supported the principle of sharing information there are substantial technical and cultural barriers. Locally there needs to be a radical change in the way operational information and knowledge management is organised across both Oxfordshire County Council and NHS Oxfordshire to more effectively support our commissioning strategy.

To begin with we intend to review what information each organisation holds and agree protocols for shared data definitions and access. Future work will encompass both the gathering of relevant information from live operational systems and the tools needed to generate forecasts, model and predict costs, and monitor the extent to which the desired outcomes are being achieved. A more holistic approach to information management will include the procurement and contract monitoring functions within the commissioning framework to ensure that all these activities are joined and co-ordinated appropriately.

12. CONCLUSION

The purpose of this document is to give a clear direction to achieve significant and measured improvement in how we plan and deliver services so that our community will be supported to age successfully. It seeks a shift in investment away from acute hospital care to health promotion, preventative approaches, primary care, integrated community services, early intervention, and rehabilitation. It has summarised the existing position with a wide of services and support for older people and the pressures for change, set out our vision for the future, and explained how we intend to deliver our plans.

In adopting it as a strategic framework for support for local people as they get older, we are making a commitment to:

- A comprehensive approach to ageing that addresses the needs of individuals in their 50s through to end of life aimed at keeping people healthy and well living independently in their own homes;
- A model of care and support based on enhanced prevention, primary care, early intervention, and integrated community provision;
- A shift of investment from treating the results of ill-health and acute hospital care towards front line innovation in primary care, community services, and health promotion.

Implementing the framework requires a radical change in approach to ageing. The transformation process presents challenges and opportunities for all partners as they respond to a fall in demand for some types of provision, such as residential care, and work to expand capacity in others such as community support. It has implications for organisational structures, service configurations, ‘back office’ functions and working patterns across the whole system in Oxfordshire.

We intend to adopt a partnership approach to this change, sharing resources to invest in frontline innovation so that public services can deliver more efficiently and managing the withdrawal of investment where appropriate. This is essential in both achieving better outcomes for people as they age and to make the most of any financial savings.

The current economic downturn and additional pressures being placed on budgets presents a challenge for joint financing to stay focused on better outcomes for people using services rather than the processes or the specific method by which the services are funded. The Health &Well Being Partnership Board will take a long-term view of this to ensure all partners join up local service spending, identify savings and achieve a step change in both service improvement and efficiency.

The Health &Well Being Partnership Board is asked to approve Ageing Successfully as a strategic framework for consultation with service users, carers, providers and other stakeholders that will guide the commissioning of services and support to older people in future years.

Appendix 1: Planning Framework

Creating a Healthy Oxfordshire established as a partnership **strategic change programme** in 2009. The purpose of the Programme Board is described as 'Developing and delivering the strategic plan for Oxfordshire in light of financial constraints' and picking up as necessary from wider system alignment issues such as Darzi care pathway configuration, difficult issues and strategic decisions to manage the removal of £240m from the health system by 2013/14. It has seven work streams of which b and d are most relevant to joint planning:

a) Shaping the Future of Primary Care (formerly Primary Care)
b) Integrated Community Services Provision
c) Acute Services
d) Integrated Commissioning (formerly Joint Commissioning)
e) Self Care and Patient Responsibility
f) Disinvestment

The Oxfordshire Partnership is responsible for agreeing the '**Sustainable Community Strategy'/ Oxfordshire 2030**, a partnership plan for improving quality of life in Oxfordshire. Its priorities are stated as:

- Create a world class economy
- Have healthy and thriving communities
- Look after our environment and respond to the threat of climate change
- Reducing inequalities and break the cycle of deprivation

This informs **The Public Service Board** which has seven thematic partnerships and is responsible for delivery of the **Local Area Agreement (LAA)** which contains 35 targets. The indicators chosen for the LAA are directly related to the priorities identified in the Sustainable Community Strategy. Some indicators relate directly to the **Health and Wellbeing Partnership Board** which is one of the seven thematic partnerships. The three priorities for the Health & Wellbeing Partnership Board are: preventing ill health in older people; reducing illness caused by obesity; mental wellbeing and monitoring of LAA targets. **The Director of Public Health's annual report** is presented to the Health & Wellbeing Partnership Board. It looks at some of the health achievements and highlights the significant issues each year.

Oxfordshire County Council approves its **Corporate Plan** annually. **Social & Community Services Leadership Team and elected members** approve Oxfordshire County Council's Social and Community Services' Directorate Plan each year and the 'Business Improvement and Efficiency Strategy'.

NHS Oxfordshire's Board of Trustees (Oxfordshire PCT) approves or refreshes its 5 year **Strategic Plan** and approves its annual **Operational Plan** annually.
This is monitored by the PCT's executive and in particular its **Ops Project Board and Assurance Groups** monitor the delivery of the **operational plan and its programme plans**. The assurance groups may change from their current make up since programmes of initiatives have recently been replaced by Darzi+ pathways.

OCC and the PCT have a large joint programme of work which is managed through **Joint Management Groups** (JMGs). These groups agree and monitor the **joint commissioning strategies**, their joint programmes of work and associated budgets. The Joint Management Groups (JMG) are*:*

1) Mental Health Commissioning JMG
2) Mental Health Provider JMG
3) Older People and Physical Disability JMG
4) Learning Disability Lead Commissioning and Pooled Budget JMG

Appendix 2: Ageing Successfully

Key Messages from Oxfordshire consultations since 2007

- People surveyed about services they use now were mostly satisfied with those services
  - 63% people using Homecare funded by OCC are extremely or very satisfied with the service [1]
  - 90% feel in control of their lives [1]
  - Residents in extra care housing like their homes, feel comfortable, safe and very satisfied with ability of staff [2]

- People want more real choices and options, and high quality in all choices
  - There shouldn't be assumptions made about where we end our lives [3]
  - There should be a range of options available to live independently [4]
  - Local services are highly valued [5]
  - Sufficient accessible day services available in rural areas [6]
  - More independent sector day services [6]
  - Services with transport plans [5]
  - Volunteer transport plans highly valued [5]
  - A good death is important wherever you are [3]

- People want to participate and contribute in their communities
  - People want to keep working indefinitely [7]
  - There should be more opportunities for volunteering [6]
  - Feeling safe and secure is important but not so it stops being part of things [4]
  - Transport needed to get to social activities [4]

- People want more and better information to make choices real
  - Only a quarter of people who use Homecare felt they were well-informed about changes [1]
  - More and better information through a single contact wanted about options about end of life [3]
  - Well-timed and targeted information, not only on the internet, about what's possible [5]
  - Information about day services needs a more positive image [6]

- People want personal contact of high quality
  - Face to face contact and the 'personal' touch highly valued [5]
  - Being listened to and not dictated to very important [4]
  - Ask what we can do, not what we can't do [4]

- Practical freedoms matter to people [4]
  - Having my own front door
  - Having enough money
  - Having a social life
  - Going out without notice
  - Preparing my own food when I want to
  - Getting support when needed

[1] *Homecare user survey Feb 2009 Oxfordshire County Council postal survey (800 respondents)*
[2] *ISIS Extra Care Housing Survey January 2008 Oxfordshire County Council with order of St John (survey residents, families, care managers)*
[3] *End of Life Consultation Event April 2009 Oxfordshire County Council (event)*
[4] *'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)*
[5] *Engaging Older People in Oxfordshire Oxfordshire Rural Community Council for Oxfordshire Primary Care Trust (569 people involved)*
[6] *A fundamental service review of Day services for Older People 2007 Oxfordshire County Council (survey and focus groups day centre users)*
[7] *Tomorrow's Older People April 2008 Oxfordshire Partnership (focus groups)*

Consultation with Carers

The Carers Commissioning Plan and the Oxfordshire Carers Strategy are based on a strong history of consultation and involvement with carers and carer organisations. Key messages include:

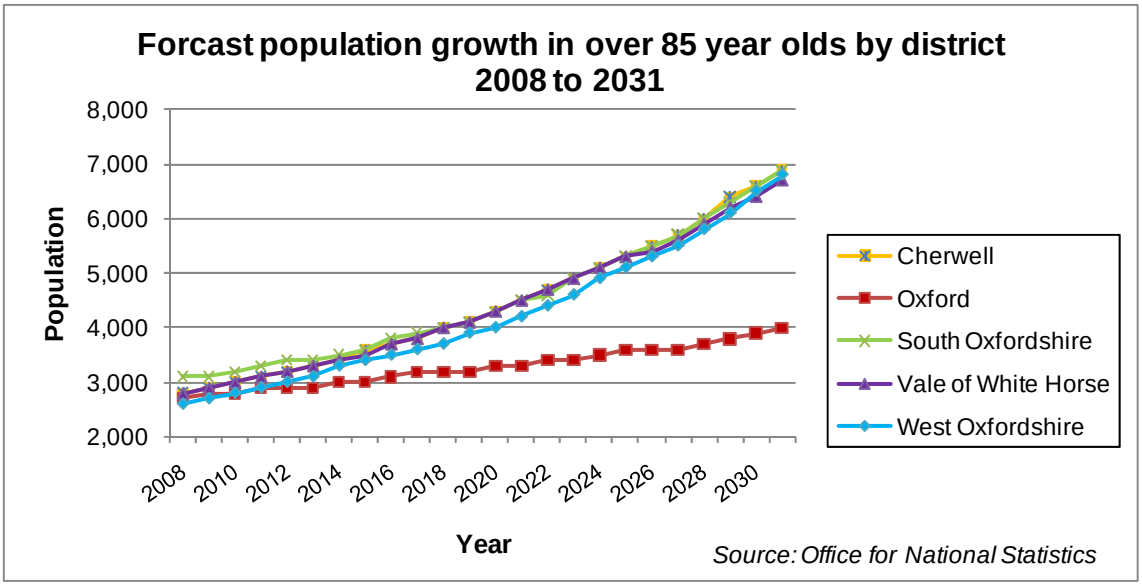
- Identification and support from GPs and primary care
- Access to flexible, timely good quality breaks
- Whole system identification and support. Access to the right information at the right time.
- Support for Carers' emotional needs; help to navigate the system, to alleviate social isolation; to learn from other carers.
- Support for transitions, whole family working.
- Replacement care and good quality advice and support for those wanting to get back into work, education etc.
- To be recognised as partners in care, expert carers.
- Equal access to information and services, taking into account diversity and special needs.

Appendix 3: Ageing in Oxfordshire

Some implications for health and social care:

- It is anticipated that 25% of people aged 85 and 30% of people over 95 will suffer from some form of dementia. The number of older people, predicted as suffering from dementia, is projected to increase from 7,303 in 2008 to 8,266 by 2015.
- 648 people aged over 65 were admitted to hospital with a fractured neck of 2007/08.
- 255 people over 65 people were given intensive support (10 hours+ per week) to live in their own homes (Jan 2009)
- Nearly 9% of the population in the county are unpaid carers, 11,136 aged over 65 have a caring responsibility that ranges from 1 hour to up to 50 hours per week.

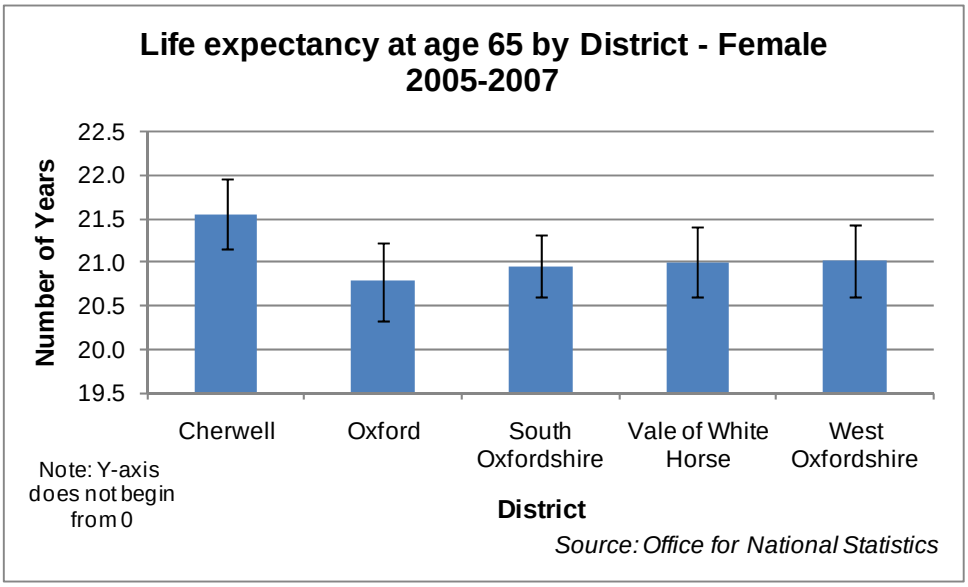
Forecast growth in over 85 year olds by district 2008 to 2030



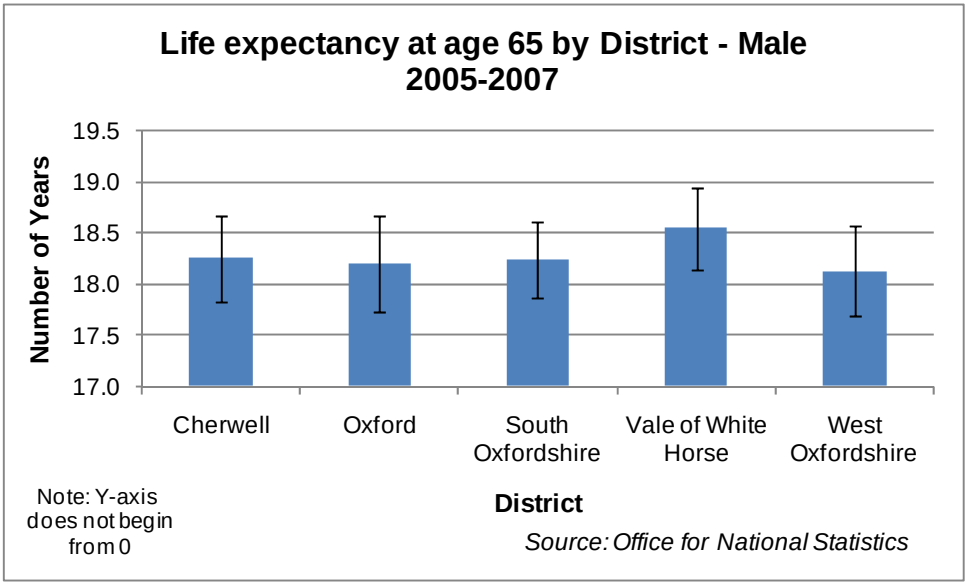
Source: Office for National Statistics

People in Oxfordshire live longer than the national average, with life expectancy continuing to increase. Life expectancy is highest in the Vale of White Horse and lowest in Oxford, though still consistently above the national average. A woman in Oxfordshire can expect to live between 82 and 83. Men can expect to live to over 78. Life expectancy at the age of 65 tells us how many years a person can expect to live after their 65th birthday.

Female Life Expectancy over 65



Male Life Expectancy over 65



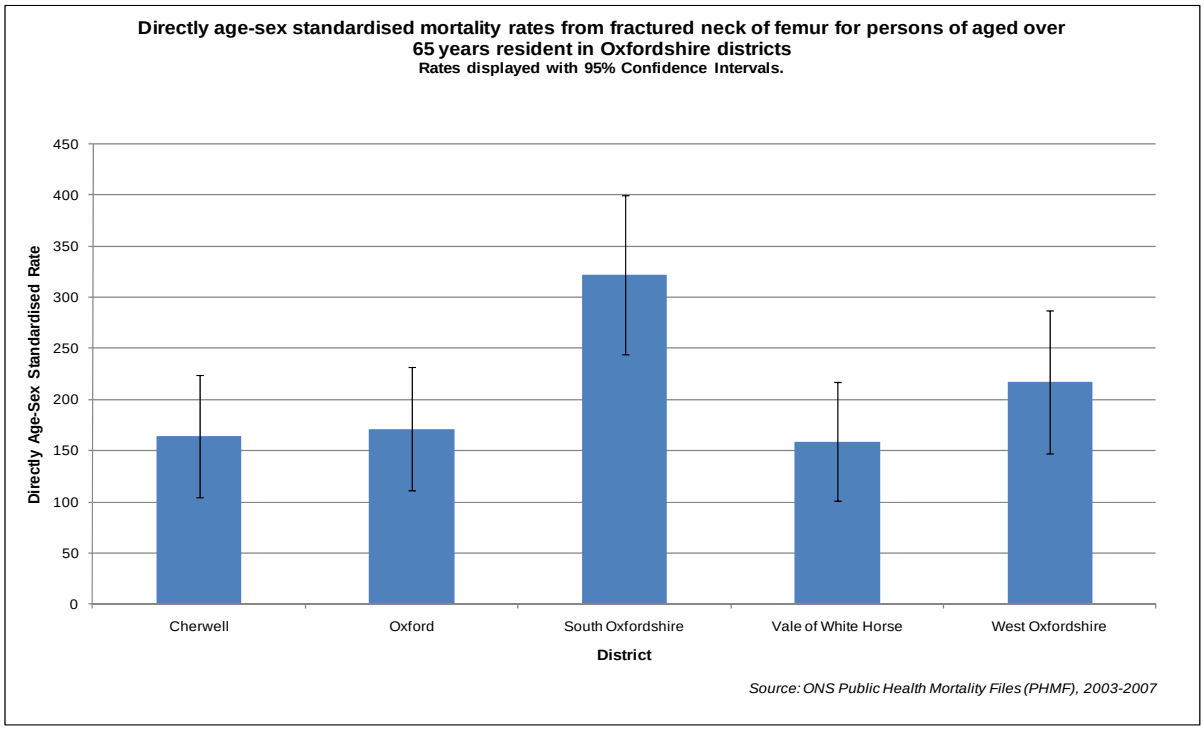
Flu vaccination

Flu can cause complications in older people, but can be prevented through vaccination. In England, almost 74% of this age group had their flu immunisation last year, compared to nearly 77% in Oxfordshire. This means that Oxfordshire had the highest rate in the South Central SHA area. While this is good news, vaccination levels in 44 Oxfordshire wards did not reach the WHO target and, of these, 26 were also below the England average.

Prevention of falls

Falls in older people can cause fractures and a loss of confidence, which impairs their ability to lead full lives and leads to long-term reductions in independence. In the over-75s in particular, admission to hospital following a fall often results in discharge to long-term care.

South Oxfordshire is the district currently experiencing the greatest number of falls - a significant difference compared to all districts other than West Oxfordshire. When considered in terms of the 13 localities, Henley/Sonning Common/Wallingford has the most falls, a result significantly higher than eight of the other 12 localities in the county. It should be remembered that these wards have a higher proportion of older people living within them. The only significant difference in hospital admissions for hip fractures at ward level was that Otmoor (highest) exceeded the four wards with the fewest cases. However, this ward contains the county's second-largest care home.



Support needs

Around one in two of the 75+ population have a 'long term limiting illness' which implies some level of disability or sensory impairment. The estimates for the number of people by district aged 75 years or over, who are living alone with a self reported long-term limiting illness indicates the highest rates of potential need are in South Oxfordshire, Oxford and Cherwell districts where they constitute more than one-fifth of the population aged 75 and over. The numbers in this group are projected to increase in all districts between 2008 and 2025 although in Oxford, this group will decline as a proportion of the total population aged 75+.

This group is a good proxy indicator for vulnerable older people who may have an emerging or imminent need for an intensive level of home care and/or be at highest risk of admission to care home provision.

Provision and availability of transport is vital to enable older people to access and develop social networks and participate as active citizens. Census data for 2001 suggests that there were 12,539 older people 65 living alone and had transport but 18,601 older people living alone without transport.

In Oxfordshire the number of people having a stroke is lower than the national average, however stroke is one of the main causes of acquired disability, and the number of people having a stroke increases after the age of 70. In Oxfordshire 5.2% of the population over 65 is living with the effects of a stroke.

Home ownership rates for older people are higher than the national average and above 70% for those aged 65-84. House prices for all types of property are consistently well above national averages.

Social Care

A number of older people use care-home services or home-care support that they have arranged themselves with private providers. Such 'self funders' very rarely access assessment from Social & Community Services prior to making a decision to purchase a care bed. There are 150 care homes in Oxfordshire, providing a total of 4,262 beds. There are an estimated 1,977 people who fund their own care home place in Oxfordshire, representing 54% of the total care home population. The absolute and relative numbers of self-funders are expected to increase. Survey evidence indicates that six per cent of the older people's population purchase their own care and a much higher percentage buy services such as help with cleaning, shopping, gardening and repairs and improvements. Most community based self-funders appear to make private unregulated arrangements for care and other help. The greater the level of care required, the higher proportion is provided by SCS

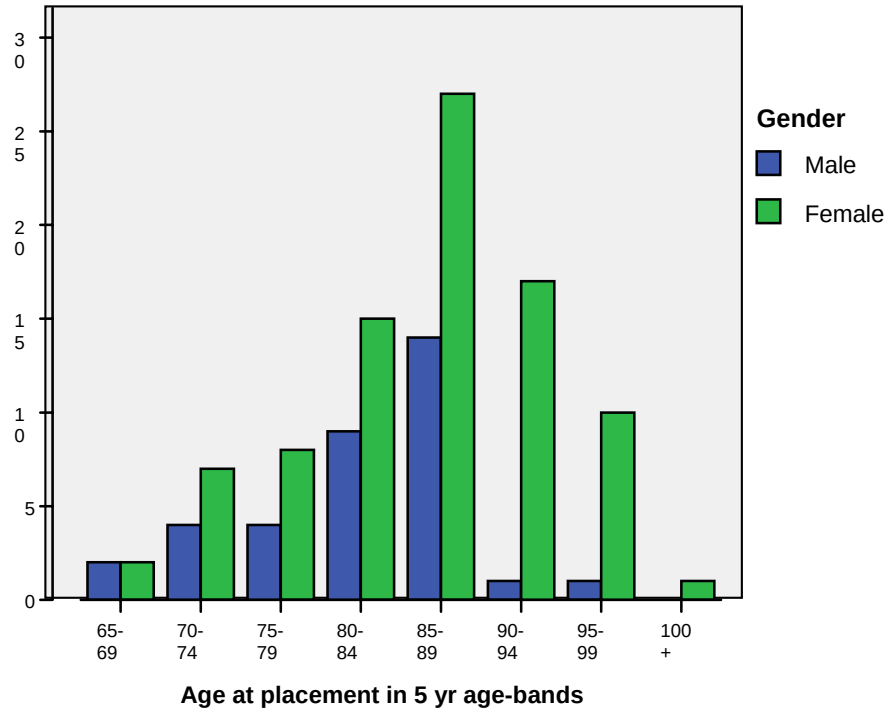
There are currently about seventy domiciliary care agencies within Oxfordshire providing services to older people. Approximately 11,568 people are receiving community based care in Oxfordshire; and of these 4,436 older people are receiving domiciliary care. 3,548 or some 40% of those in receipt of community based care will be paying for all or some of their care. It is estimated that 1,685 or 19% of older people receiving community based care will privately purchase the entirety of their service requirements.

Admission into long-term care

Oxfordshire research into admission to a residential care home found that limited mobility, followed by incontinence and dementia, were by far the most-common conditions amongst those admitted. Depression was found amongst a quarter of those going into a home and both stroke and visual impairment were common (found in a fifth of people). As shown in the graph below, the average age at admission was 85 years. Men appear to be likely to be admitted to care at an earlier age than women. The median age at placement was 85.0 years old, with a range from 65 to 103.

The great majority of people going into care were White British (97.5%).This is similar to the profile of older people in Oxfordshire aged 85 and above. More than three out of five (64%) of those admitted had been living alone, with 18% living with their spouse or partners and 18% living with another family member prior to admission. In comparison, less than 50% of people aged 75+ are estimated to live alone in Oxfordshire. More than three-fifths (61%) were admitted from hospital. Where information was recorded, nearly two-fifths (39%) had been in hospital for eight weeks or more prior to admission.

Number of older people placed in a care home by Oxfordshire County Council (based on sample of approx 25% of admissions in 2008/ 2009)



Limited mobility was also common among those being admitted. At least 57% had some difficulty walking about, while 11% were unable to walk about. Some people had a large number of health problems, including arthritis (9%). In comparison with the general population, the levels of ill-health were well above national prevalence rates for incontinence, dementia and stroke.

Falls

The data indicates that more than one-quarter (26%) of people had had a fall requiring hospital admission in the last 12 months; and 18% had had a fall which did not require hospital admission in the last 12 months. Allowing for those who had had both types of fall, two-fifths (40%) had had some kind of fall in the last 12 months.

Housing

In nearly one-third of cases (30%) where information about housing was available, the person's current housing was not appropriate. The reasons cited include: four first floor flats without a lift; four others with stairs to, or inside, the accommodation; five lacked downstairs toilets. At least 12% had received adaptations to their homes.

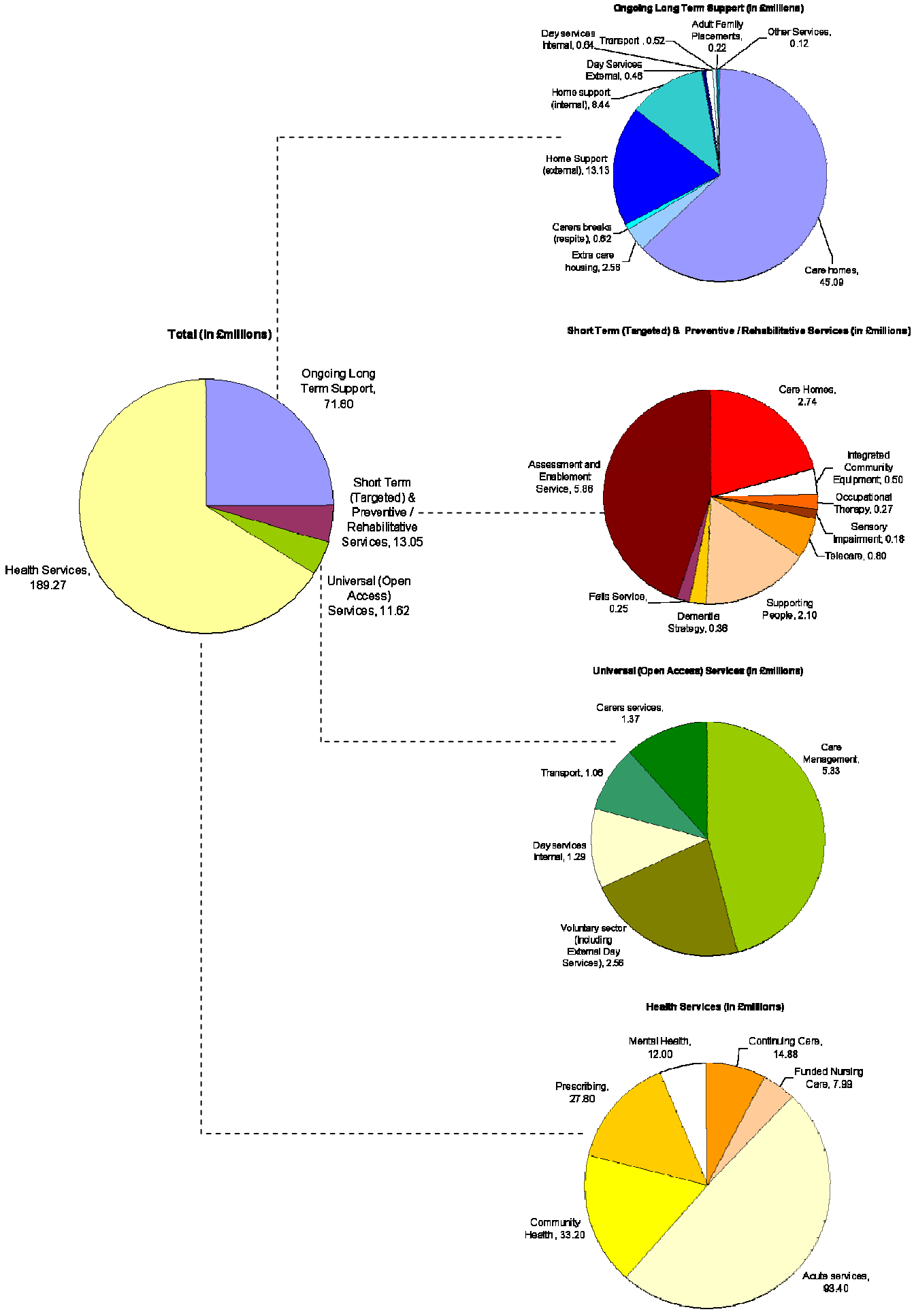
The increasing number of people ageing makes this an ideal opportunity to ensure any changes to: the physical fabric of urban and rural spaces; the network of public transport; community safety; leisure amenities and employment opportunities beyond retirement are suited to their needs.

Appendix 4: Current preventative service provision in Oxfordshire:

	Universal / Primary interventions & services	Selective / Secondary interventions & services	Indicated /Tertiary interventions and services
	Keep people well	*Prevent decline, disease progression and loss of independence*	*Minimise disability and deterioration, prevent avoidable entry to hospital and residential care, maximise functioning and independence.* *Restore and rehabilitate.*
Type / Stage specific examples of preventative services	Building Stronger Communities Primary Care Services including Dentistry, GP's etc Healthy Lifestyle Awareness Flu & Pneumococcal Immunisations Housing & the home[18] Information, advice and sign-posting	Screening for disease, including breast, bowel and cervical cancers Targeted interventions to improve lifestyles Expert Patient Programme & self care programmes Shopping & gardening etc Interagency referral scheme Referral to specialist health advice services eg. falls, continence, LTCs, self care programme for LTCs Case Finding Lunch clubs Shopping, gardening etc Benefits advice Transport services – voluntary sector[19] Sole Mates – footcare / podiatry Bereavement counselling	Extra care housing Structured Exercise & Falls prevention service Transport services to social and community services Intermediate care and rapid response services[20]
Characteristic of all 3 stages	Smoking cessation, Telecare Continence Services Falls Service		
Characteristic of secondary and tertiary stages		Home support Day services Befriending and counselling Support to carers OT equipment, aids and adaptations Case management of those at risk	

[18] Also covered in the 'Building Stronger Communities' section
[19] Also covered in the 'Building Stronger Communities' section
[20] Currently provided through the Integrated Access and Enablement Service (AES)

Appendix 5: Outline of Health and Social Care Expenditure 2009/10



Appendix 6: National and local strategic documents

Building Stronger Communities

The following key documents inform 'Ageing Successfully':

- NHS World Class Commissioning
- NHS Operating Framework
- High quality care for all: NHS Next Stage Review final report (Darzi)
- Our Health Our Care Our Say (Department of Health (DH) 2006)
- Putting People First/ Transformation of Adult Social Care
- Commissioning Framework for Health & Wellbeing
- Building a Society for all Ages (HM Government 2009)
- New Horizons: towards a shared vision for mental health
- Improving Life Chances of Disabled People
- Right to Control
- Personal care budgets
- National Carers Strategy
- National Dementia Strategy
- National Stroke Strategy
- National Service Framework for neurological / Long Term Conditions
- Shaping the Future of Care Together - Green paper
- Equality Bill (HM Government 2009)
- Health, Work, and Wellbeing – Caring for our future (2009)
- Lifetime homes, lifetime neighbourhoods (DH, DWP 2008)
- Don't Stop Me Now – preparing for an older population (audit Commission 2008
- Commissioning Framework for Health & Wellbeing (DH 2006)
- A Sure Start to Later Life (DOH, DWP 2006)
- Choosing Health (2004)
- South East England Health Strategy (2008)
- Oxfordshire Sustainable Community Strategy: Oxfordshire 2030
- District Sustainable Communities Strategies
- District Community Safety Strategies
- District Housing Strategies
- Oxfordshire Public Health Strategy
- Oxfordshire PCT Strategy
- Oxfordshire DPH Annual Report's I, II & III
- LAA Agreement targets:
- NI6 – Increasing participation in volunteering
- NI7 –
- NI21- Dealing with local concerns about antisocial behaviour and crime by the local council and police PSA
- NI8 – Adult participation in sport
- N120 – All age, all cause mortality rate

Carers

- Carers (Recognition and Services) Act 1995
- Carers and Disabled Children Act 2000
- Carers (Equal Opportunities) Act 2004
- Work and Families Act 2006
- Putting People First 2007
- National Carers Strategy 2008-2018
- National Dementia Strategy 2008
- LAA2 NI 135 to increase the number of Carers receiving needs assessment or review and specific carers' service, or advice and information as a proportion of all clients receiving community based services.
- Oxfordshire Carers Strategy 2009-12
- Oxfordshire Young Carers Strategy 2008-13
- Local Govt and Public Involvement in Health Act – Duty to involve from 4/09
- Equalities Bill 2010
- Oxfordshire Carers' Commissioning Plan 2010 - 2013